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PART 1. Overview Information

Department of Health and Human Services

Federal Agency Names

Office of the Assistant Secretary for Preparedness and Response (ASPR)

Centers for Disease Control and Prevention (CDC)

Funding Opportunity Title: Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements

Announcement Type

New – Type 1

Agency Funding Opportunity Number CDC-RFA-TP12-1201

Catalog of Federal Domestic Assistance Numbers

93.889 – National Bioterrorism Hospital Preparedness Program

93.069 – Public Health Emergency Preparedness

Key Dates

To receive notification of any changes to CDC-RFA-TP12-1201 return to the synopsis page of this announcement at www.grants.gov and click the "Send Me Change Notification E-mails" link. An e-mail address is needed for this service.

Application Deadline: To receive consideration, electronic cooperative agreement funding applications must be submitted: ***May 01, 2012*** **no later than 11:59 p.m. U.S. Eastern Time 60 calendar days after publication on www.grants.gov**.

Executive Summary

Threats to human health and national health security are always present. Whether caused by natural, unintentional, or intentional means, these threats can rapidly overwhelm public health and healthcare systems. Preparing governmental jurisdictions, communities, health and emergency response systems, and other Emergency Support Function (ESF) #8 partners to prevent, protect against, respond to, mitigate, and rapidly recover from these threats is critical for protecting and securing our nation's healthcare system and public health infrastructure.

HPP-PHEP Grant Alignment

Public health and healthcare preparedness is achieved when component partners at the federal, state, local, tribal, territorial, and nongovernmental levels work in synergy to prepare for, respond to, and rapidly recover from health security incidents and emergencies.

To advance all-hazards preparedness and national health security, promote responsible stewardship of federal funds, and reduce awardee administrative burden, the U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and Centers for Disease Control and Prevention (CDC) are aligning the administrative and programmatic aspects of the ASPR Hospital Preparedness Program (HPP) and the CDC Public Health Emergency Preparedness (PHEP) cooperative agreements. This funding opportunity announcement describes the ASPR and CDC terms and conditions of the award, the overall purpose of the HPP and PHEP programs, and strategies for achieving program outcomes.

As ASPR and CDC align the two preparedness programs, which represent critical sources of funding and support to our nation's public health and healthcare preparedness systems, ASPR and CDC are committed to the following goals:

- Increase program impact and advance preparedness
- Reduce awardee burden and enhance customer service provided to states and localities
- Improve federal efficiencies
- Promote innovation
- Demonstrate a clear return on investment and communicate preparedness accomplishments to help ensure sustainability of the PHEP and HPP cooperative agreements

This alignment has resulted in several key changes for the 2012 HPP-PHEP grant cycle. Among the changes are a single HPP-PHEP funding opportunity announcement, funding application, and grant award. An aligned grant cycle is also being implemented, as well as aligned reporting requirements. The annual HPP-PHEP grant cycle will begin July 1 and end June 30.

The new HPP-PHEP project period is five years. Funding applications for Budget Period 1 of the new cooperative agreements are due no later than 60 calendar days after publication on www.grants.gov. Budget Period 1 begins July 1, 2012. Available fiscal year 2012 funding for Budget Period 1 is $351,644,731 for the HPP program and

$619,447,806 for the PHEP program. Funding is intended to help awardees demonstrate measurable and sustainable progress toward achieving the public health and healthcare preparedness capabilities outlined in this guidance and other activities that promote safer and more resilient communities.

Capabilities-based Approach

HPP and PHEP awardees have made significant progress over the past decade in building and sustaining public health and healthcare preparedness capabilities. The aligned HPP and PHEP cooperative agreement programs support the National Health Security Strategy and follow a capabilities-based approach, building upon the strong preparedness foundation already in place at the state and local levels.

The HPP and PHEP cooperative agreements are authorized by sections 319C-1 and 319C-2 of the Public Health Service (PHS) Act as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006[1]. The purpose of PAHPA is to improve the nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural. HPP and PHEP are consistent with PAHPA and Presidential Policy Directive (PPD) 8: National Preparedness, which aims to strengthen the security and resilience of the United States through systematic preparation for the threats that pose the greatest risk to the security of the United States. PPD 8 directs the development of a National Preparedness Goal, which was adopted in

[1] Congress is considering legislation to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006. Until new legislation is signed into law, Congress has funded the HPP and PHEP cooperative agreement programs in accordance with the existing provisions of sections 319C-1 and 319C-2.

September 2011 and establishes the 35 core capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk.

Consistent with this national approach to planning through the development of "whole-of-community" approaches, ASPR and CDC developed the following documents to serve as foundational guidance for the aligned programs: *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* (http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf) and *Public Health Preparedness Capabilities: National Standards for State and Local Planning (*http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf).

This announcement is only for nonresearch activities supported by ASPR and CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

PART 2. FULL TEXT

Section I. Funding Opportunity Description

Statutory Authority

Hospital Preparedness Program Funding (HPP): 319C-2 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417) (2006).

Public Health Emergency Preparedness Program Funding (PHEP): 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417) (2006).

Contingent Emergency Response Funding (PHEP Only)

317(a) and 317(d) of the PHS Act, subject to available funding and other requirements and limitations.

This guidance describes a separate mechanism for awarding future **contingent emergency response funding** that may be issued in the event of a pandemic or an all-hazards public health emergency in one or more jurisdictions. Such funding is subject to restrictions imposed by CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and

circumstances that exist at the time of the emergency; the particular appropriation from which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. Funding will be subject to the funding authority, e.g., sections 317(a) and (d) of the PHS Act, the relevant notice of award, including restrictions imposed at the time of the emergency, and applicable grants regulations and policies. No activities are specified for this authorization at this time.

Background and Rationale

Interagency Grant Coordination

Several federal partners, namely ASPR, CDC, HHS' Health Resources and Services Administration (HRSA), the Department of Homeland Security's Federal Emergency Management Agency (FEMA), and the Department of Transportation's (DOT) National Highway Traffic Safety Administration (NHTSA), distribute preparedness funds and/or provide technical assistance in support of a variety of homeland security, emergency management, public health, and healthcare preparedness activities. Some agencies provide direct emergency public health and healthcare systems preparedness grant funding support to states and local and private entities. Other agencies help to coordinate federal agencies involved with state, local, tribal, and regional emergency medical services and develop projects of national significance which are important components of ensuring consistent national strategies.

Improved coordination among federal emergency preparedness programs is a high-level priority of many entities, including the White House National Security Staff, the Office

of Management and Budget, and HPP and PHEP awardees. In December 2010, an Interagency Work Group from ASPR, CDC, HRSA, FEMA, and NHTSA engaged in an interest-based, consensus-building process to co-develop goals, strategies, and action plans to better align grants with public health and healthcare preparedness components.

In July 2011, these agencies signed a memorandum of understanding (MOU), agreeing to cooperatively assess current preparedness grant programs and to engage in collaborative efforts to improve interagency grant coordination. The MOU establishes a formal framework that supports joint federal planning designed to focus investments and to improve and measure preparedness.

HPP-PHEP Grant Alignment

ASPR and CDC have aligned the HPP and the PHEP cooperative agreements through development of key points of intersection. These include:

- One funding opportunity announcement, funding application, and grant award
- Integrated technical assistance, site visits, and annual joint preparedness conferences
- Data management, reporting, and alignment of business processes
    - Common Web-based IT portal for awardees
    - One grants administration agency
    - Aligned HPP and PHEP grant cycles
- Aligned preparedness capabilities
- Co-development of some performance measures

- Consistent budgetary requirements
- Engagement of stakeholders

Benefits of State and Local Coordination

Awardees have made significant progress over the past decade in building and sustaining public health and healthcare preparedness capabilities. The aligned HPP and PHEP cooperative agreement programs will follow a capabilities-based approach, building upon the strong preparedness foundation already in place at the state and local levels. In addition, this joint funding opportunity announcement is intended to foster and accelerate alignment of HPP and PHEP programs in the 62 awardee jurisdictions.

At the state and local levels, many PHEP and HPP programs already are closely aligned, and CDC and ASPR have similarly aligned to better support state and local efforts. The benefits of greater alignment of HPP and PHEP programs in the 62 awardee jurisdictions include:

- More coordinated and integrated public health and healthcare system planning and response
- Improved ability to leverage funding for applicable activities and infrastructure
- Reduced awardee burden regarding duplicative and sometimes conflicting activities and redundant reporting

HPP and PHEP grant alignment is a long-term initiative that will continue to evolve throughout the project period as the two programs seek additional opportunities to improve administrative and programmatic collaboration in the joint administration of the

HPP and PHEP cooperative agreements. While working toward closer alignment in many aspects, ASPR and CDC recognize that the capabilities required to fulfill HPP and PHEP programmatic goals differ and that both programs will continue to remain stand-alone programs in accordance with their authorizing legislation.

National Standards for Public Health and Healthcare Preparedness

Regardless of the threat, strong and resilient public health and healthcare systems are the cornerstone of an effective response at the local level. Public health departments have made significant progress since 2001, as demonstrated in the ASPR report, *From Hospitals to Healthcare Coalitions: Transforming Health Preparedness & Response in Our Communities,* http://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-healthcare-coalitions.pdf, and CDC's state preparedness reports (http://www.cdc.gov/phpr/pubs-links/pubslinks.htm). However, state and local planners have expressed concerns over their ability to sustain the real and measurable advances made in public health and healthcare preparedness since September 11, 2001, when Congress appropriated funding to expand its support nationwide for public health and healthcare preparedness programs.

ASPR and CDC have developed preparedness capabilities with complementary content that describes how each discipline – public health and healthcare systems – contributes expertise to each capability, promoting safer, more resilient communities. The public health and healthcare preparedness capabilities are designed to help state and local health departments with their strategic planning. Released in March 2011, CDC's *Public Health*

Preparedness Capabilities: National Standards for State and Local Planning establishes national standards for public health preparedness capabilities-based planning that assists state and local planners in identifying gaps in preparedness, determining specific jurisdictional priorities, and developing plans for building and sustaining public health capabilities.

Similarly, ASPR has defined healthcare preparedness capabilities to assist healthcare systems, healthcare coalitions, and healthcare organizations with developing preparedness and response strategies. Released in January 2012, the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* assists state, local, healthcare coalition, and ESF #8 partners in identifying gaps in preparedness, determining specific priorities, and developing plans for building and sustaining healthcare-specific capabilities.

Aligning Capabilities with National Strategies

The preparedness capabilities are based on evidence-informed documents, applicable preparedness literature, and subject matter expertise gathered from across the federal government and the state and local practice community. The capabilities align with public health and healthcare preparedness priorities in key legislative and executive directives, including:

- Sections 319C-1 and 319C-2 of the PHS Act, as amended by PAHPA, which authorizes the PHEP and HPP cooperative agreement programs;

- Homeland Security Presidential Directives (HSPD) 5 and 21;
- Presidential Policy Directive 8: National Preparedness. PPD 8 focuses on key capabilities and "whole-of-community" approaches that break down preparedness barriers. PPD 8 replaces HSPD 8 (2003) and HSPD-8 Annex I (2007) and aims to strengthen the security and resilience of the United States through systematic preparation for threats to the nation's security, including acts of terrorism, pandemics, significant accidents, and catastrophic natural disasters; and
- National Health Security Strategy (NHSS) and its core capabilities: community resilience and recovery; infrastructure; situational awareness; incident management; disease control and mitigation; healthcare services; population safety and health; and quality improvement and accountability.

HPP-PHEP Cooperative Agreement Purpose

The purpose of the 2012-2017 HPP-PHEP cooperative agreement programs is to provide technical assistance and resources that support state, local, territorial, and tribal public health departments and healthcare systems/organizations in demonstrating measurable and sustainable progress toward achieving public health and healthcare preparedness capabilities that promote prepared and resilient communities.

Program Implementation

HPP and PHEP program implementation activities should be focused on development of all healthcare and public health capabilities. Awardees are expected to use their

cooperative agreement funding to build and sustain the public health and healthcare preparedness capabilities, ensuring that federal preparedness funds are directed to priority areas within their jurisdictions as identified through their strategic planning efforts. Awardees must demonstrate measurable and sustainable progress toward achieving all the preparedness capabilities over the five-year project period. In addition, awardees should be able to describe how effective implementation activities and programs have met the needs of at-risk individuals (also known as vulnerable or special needs) as required under PAHPA. The definition of at-risk individuals is available at: http://www.phe.gov/Preparedness/planning/abc/Documents/at-risk-individuals.pdf.

Cross-cutting HPP and PHEP activities should be managed, coordinated, and integrated where applicable. To further advance public health and healthcare preparedness, awardees should consider organizing their programs to align and integrate with jurisdictional preparedness planning priorities. Establishing such an organizational structure will help assure public health and healthcare preparedness program components are integrated and associated requirements are achieved, helping to assure more effective coordination, administration, and oversight of strategic and tactical program implementation activities.

Public health and healthcare systems have complementary yet unique characteristics, and both have specific preparedness and response roles. Grant alignment efforts are intended to maintain the uniqueness of each program, while ensuring both programs are jointly

planning, exercising, and implementing program operations in a more coordinated fashion. Examples of potential joint activities or shared services include:

- Exercise planning and conduct
- Healthcare coalition planning
- Implementation of joint capability resource elements and tasks
- Information technology services
    - Health Alert Networks (HAN)
    - Communication platforms

In addition, HPP-PHEP grant alignment is designed to promote efficiencies through appropriate pooling of resources and leveraging of funds for applicable services, activities, and infrastructure while maintaining separate appropriation identities. However, leveraged funding must be used to support joint HPP-PHEP requirements. For instance, an integrated HPP-PHEP program at the awardee level could have one administrative structure that supports both programs. Examples of could include but are not limited to:

- Preparedness director
- Planners
- Exercise development staff
- Contract support staff
- Administrative assistants
- Legal support staff
- Grants management staff

- Evaluation staff
- Public information officers

Recipient Activities

Public Health and Healthcare Preparedness Capabilities

ASPR and CDC have identified the following 15 public health and 8 healthcare capabilities as the basis for state and local public health and healthcare preparedness.

	Public Health Preparedness Capabilities	**Healthcare Preparedness Capabilities**
1	Community Preparedness	Healthcare System Preparedness
2	Community Recovery	Healthcare System Recovery
3	Emergency Operations Coordination	Emergency Operations Coordination
4	Emergency Public Information and Warning	
5	Fatality Management	Fatality Management
6	Information Sharing	Information Sharing
7	Mass Care	
8	Medical Countermeasure Dispensing	
9	Medical Materiel Management and Distribution	
10	Medical Surge	Medical Surge
11	Non-pharmaceutical Interventions	

12	Public Health Laboratory Testing	
13	Public Health Surveillance and Epidemiological Investigation	
14	Responder Safety and Health	Responder Safety and Health
15	Volunteer Management	Volunteer Management

Each of the public health and healthcare preparedness capabilities includes a definition of the capability and a list of the associated functions, tasks, and resource element considerations. Public health departments should *have* or *have access to* the priority resource elements included in the public health preparedness capabilities to fully achieve those capabilities. In addition, HPP awardees are required to assess and address all planning resource elements in the healthcare preparedness capabilities to fully achieve those capabilities. (See Appendices 4 and 5 for more information on the capabilities and resource elements.)

ASPR and CDC have developed capabilities planning models that describe high-level planning processes awardees can use to help determine their preparedness priorities, plan appropriate preparedness activities, and demonstrate and evaluate achievement of capabilities. These processes also will assist awardees in developing required capabilities plans that must be submitted as part of their funding applications. (See Section IV.) The ASPR planning model is available at http://www.phe.gov/Preparedness/planning/hpp/Pages/default.aspx. The CDC planning model is available at http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf.

Prioritization of Healthcare Preparedness Capabilities

All capability planning resource elements must be addressed through a narrative outlining the status of completion as part of the capabilities work plan. Budget allocations will be focused at the function and resource element levels only. Full details on the required functions and resource elements that must be addressed in the capabilities work plan are available in Appendix 4. After work plans are completed, awardees should then prioritize within the eight healthcare preparedness capabilities those functions and resource elements for additional budget allocation based on their unique healthcare delivery preparedness needs as determined through the planning process, as well as all HPP requirements found in this funding opportunity announcement. This prioritization process is covered in Capability 1: Healthcare System Preparedness and includes:

1. The jurisdictional risk assessment/hazard vulnerability process
2. Resources assessment and gap analysis based on the status of the current capabilities
3. Development of priorities based on risk and need

Prioritization of Public Health Preparedness Capabilities

CDC strongly recommends that PHEP awardees prioritize their work and resulting investments regarding the 15 public health preparedness capabilities across the five-year project period based upon: 1) their jurisdictional risk assessments (see the Community Preparedness capability for additional or supporting detail on the requirements for this risk assessment), 2) an assessment of current capabilities and gaps using CDC's *Public*

Health Preparedness Capabilities: National Standards for State and Local Planning and the awardee capability self-assessment process, and 3) CDC's recommended tiered strategy for capabilities:

Tier 1 Public Health Preparedness Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing

Tier 2 Public Health Preparedness Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge*
- Volunteer Management*
- Community Recovery
- Fatality Management*
- Mass Care

*PHEP funding should support the development of these Tier 2 capabilities in coordination with HPP activities.

CDC's tiered strategy is designed to emphasize the Tier 1 capabilities as they provide the foundation for public health preparedness. PHEP awardees are strongly encouraged to build the priority resource elements in the Tier 1 capabilities prior to making significant or comprehensive investments in Tier 2 public health preparedness capabilities.

To date, ASPR does not tier its healthcare preparedness capabilities and expects HPP awardees to prioritize funding based on their planning model consistent with the planning process of the U.S. Department of Homeland Security preparedness cycle, which is outlined in Chapter 4 of FEMA's *Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0.* (See Appendix 4.) Through continued refinement resulting from information obtained from the awardee capability self-assessment process and further stakeholder engagement, ASPR may elect to provide HPP awardees with a tiered approach in subsequent budget periods.

Everyday Use. Each of the public health and healthcare preparedness capabilities identifies priority resource elements that are relevant to routine public health and healthcare activities and essential public health and healthcare services, as well as preparedness and response. Awardees can demonstrate achievement of capabilities through different means (e.g., exercises, planned events, and real incidents). In addition

to exercises, awardees are encouraged to use routine activities and real incidents to evaluate their public health and healthcare preparedness capabilities when feasible.

Jurisdictional Risk Assessments

A central component of implementing a capability-based approach to preparedness and response efforts includes jurisdictional risk assessments (JRA) that identify potential hazards, vulnerabilities, and risks within the community that relate to the public health, medical, and mental/behavioral systems inclusive of at-risk individuals. (See Healthcare Preparedness Capability 1: Healthcare System Preparedness in Appendix 4 and Public Health Preparedness Capability 1: Community Preparedness in Appendix 5.) Jurisdictional risk assessment planning should use an all-hazards approach and include input from existing hazard and vulnerability assessments conducted by emergency management, healthcare organizations, and community partners. Awardees should use the results of their most current state, regional, and/or community-based JRA to help determine their gaps within each of the capabilities.

Program Strategies and Requirements

For Budget Period 1 of the new HPP-PHEP cooperative agreement project period, awardees must address and comply with joint program requirements, as well as specific HPP and PHEP requirements.

Joint HPP-PHEP Requirements

1. Foster greater HPP and PHEP program alignment. Awardees must demonstrate progress in coordinating public health and healthcare preparedness program activities and leveraging funding to support those activities and also track accomplishments highlighting the impact of the HPP and PHEP programs in awardee jurisdictions.

2. Conduct jurisdictional risk assessments. Awardees are required to conduct jurisdictional risk assessments (JRA) to identify potential hazards, vulnerabilities, and risks within the community that relate to the public health, medical, and mental/behavioral systems and the functional needs of at-risk individuals. Jurisdictional risk assessment planning should be a collaborative and flexible process that includes input from existing hazard and vulnerability assessments conducted by emergency management and healthcare organizations as well as community and regional partners. Awardees should use the results of their most current state, regional, and/or community-based JRA to help determine their gaps within each of the public health and healthcare capabilities.

   HPP and PHEP awardees should develop public health, medical, and mental/behavioral health-focused JRAs in coordination with emergency management and community partners that, where applicable, utilize findings from their state or regional threat hazard identification risk assessment (THIRA). More information is available at http://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf.

3. Develop and implement administrative preparedness strategies. For the purposes of this FOA, administrative preparedness is defined as the process of ensuring that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond to, and recover from public health emergencies can be accelerated, modified, streamlined, and accountably managed at all levels of government. HPP and PHEP awardees should establish plans to effectively receive, obligate, and account for HPP and PHEP funds that are consistent with the purpose of the HPP and PHEP cooperative agreements. Plans must include the ability to move funding to the local level in a timely and effective manner.

   It is critical that as awardees apply resources to achieve the public health and healthcare preparedness capabilities, they also plan how they will address the additional fiscal and administrative challenges they may face during a public health emergency. To ensure that these potential challenges are addressed, response plans should include emergency authorities and expedited administrative processes that would likely differ from the awardees' standard procedures. As applicable, formal incident action plans (IAPs), after-action reports (AARs), improvement plans (IPs), awardee capability self-assessment data, and jurisdictional risk assessments may be considered in providing the actions taken or planned to overcome challenges and barriers within the scope of administrative preparedness.

In addition to the application project narrative, which describes the standard administrative operating procedures, awardees should develop and submit plans to ASPR and CDC no later than September 30, 2012, that address the following three areas:

- Alignment of the HPP-PHEP administrative processes: Describe how funds will be managed between the two programs, including processes for:
  - Streamlining and consolidating contracting procedures;
  - Tracking HPP and PHEP funds separately;
  - Tracking match and maintenance of funding/maintaining state funding requirements separately;
  - Meeting fiscal reporting requirements, including timely submission of separate SF 425 Federal Financial Reports (FFRs);
  - Conducting required A-133 audits and other program audits as required; and
  - Designating authorized official(s) to access the payment management accounts to draw down HPP and PHEP funds.

- Describe and provide citations for the following awardee emergency legal authorities:
  - Expedited procedures for receiving, allocating, and spending emergency funds, including the ability to quickly move emergency funds from the state level to local governments;

- Waivers or similar legal processes that can be used to minimize the potential conflicts between emergency use authorizations (EUA) and state-based pharmaceutical, prescribing, labeling, and other drug-related laws. If no waivers or similar legal processes exist, please describe laws that may potentially conflict with EUAs;
- Formal memoranda of understanding or agreement (MOU/MOA) for joint investigations of intentional public health threats or incidents, signed and executed between the appropriate Federal Bureau of Investigation field office and state public health departments, and including local public health departments where relevant (such as in home rule states); and
- Protection of volunteers against tort liability and workers' compensation claims (excluding federal mechanisms, e.g., the Public Readiness and Emergency Preparedness Act). Please distinguish between in-state and out-of-state volunteers and indicate whether your state can use the Emergency Management Assistance Compact to send or receive volunteers.

- Describe expedited fiscal and other administrative processes, such as:
  - Emergency procurement and contracting authorities and processes and how they differ from day-to-day business processes;
  - Emergency hiring processes (workforce surge) and how they differ from customary hiring processes;
  - Reporting/monitoring methodology to ensure payment efficiency and funding accountability; and

- Emergency procedures for allocating funds to local and tribal health departments and other subawardees.

4. Coordinate exercise planning and implementation. Awardees must develop multiyear exercise plans for conducting exercises to test public health and healthcare preparedness capabilities. In addition, awardees must conduct one joint, full-scale exercise within the five-year project period. Joint exercises should meet multiple program requirements, including HPP, PHEP, and Strategic National Stockpile/Cities Readiness Initiative/CHEMPACK requirements (see Appendix 10) to help minimize the burden on exercise planners and participants. Exercise plans must demonstrate coordination with relevant entities and include methods to leverage resources to the maximum extent possible. Exercise plans must be submitted annually on or before the funding application deadline to the CDC/DSLR secure channel on www.llis.gov. Plans must include proposed exercise schedules and describe exercise goals and objectives, identified capabilities to be tested, inclusion of at-risk individuals, participating partner organizations, and previously identified improvement plan items from real incidents or previous exercises. This multiyear exercise plan must be updated annually and should comply with additional HPP- and PHEP-specific exercise requirements outlined in the HPP and PHEP program requirement sections.

5. Healthcare coalition planning. Awardees must contribute to successful coordinated preparedness. To do so, a plan must be developed to coordinate

preparedness efforts among healthcare, public health, and behavioral health at the healthcare coalition level. This plan must include the strategy which HPP and PHEP awardees will use to encourage coordinated preparedness between healthcare and public health as well as how they will interact and plan with the primary preparedness agency and their partners at the jurisdictional level. Plans must be submitted by September 30, 2012.

6. Integrate preparedness efforts across jurisdictions. Awardees must establish and maintain advisory committees comprised of senior officials from governmental and nongovernmental organizations involved in homeland security, healthcare, public health, and behavioral health to integrate preparedness efforts across jurisdictions and to leverage funding streams. This will enable HPP and PHEP program components as a whole to complement and better coordinate with other public health and preparedness programs as applicable.

   The membership of the senior advisory committee must, at a minimum, and to the extent allowed by applicable law, include jurisdictional officials directly responsible for the administration of Department of Homeland Security preparedness grants and ASPR and CDC preparedness cooperative agreements, such as the:

   - State administrative agency (SAA),
   - Jurisdictional HPP director, principal investigator, or coordinator,
   - Jurisdictional PHEP director or principal investigator,

- Jurisdictional emergency management agency representative,
  Jurisdictional emergency medical services representative,
- Jurisdictional medical examiner, and
- Jurisdictional hospital representative.

Awardees are strongly encouraged to broaden advisory committee membership to include representatives from additional disciplines (e.g., legal counsel and finance), local jurisdictions and associations, and regional working groups. Advisory committees should also include citizen representation, including those representing at-risk individuals, to obtain public input and comment on emergency preparedness planning.

7. Obtain public comment and input on public health emergency preparedness and response plans and their implementation, using existing advisory committees or a similar mechanism to ensure ongoing public comment and to obtain comment from other state, local, and tribal stakeholders. (See Appendix 4: Healthcare System Preparedness capability, Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster; See Appendix 5: Community Preparedness capability, Function 2: Build community partnerships to support health preparedness.)

8. Meet Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) compliance requirements. (See Appendix 4:

Volunteer Management capability, Function 1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations; Appendix 5: Volunteer Management capability, Function 1: Coordinate volunteers; and Appendix 12: ESAR-VHP Compliance Requirements.)

9. Engage in technical assistance planning. Awardees must actively work with ASPR and CDC project officers to develop individualized technical assistance plans within 90 days of the start of the budget period. The consolidated HPP-PHEP technical assistance plans will include awardee-identified and project officer-identified technical assistance needs and a joint strategy for addressing those needs. Technical assistance plans will be monitored on a regular basis and updated by project officers and awardees as part of the mid-year review process.

10. Plan and conduct joint site visits. Awardees should be actively involved in the planning and execution of routine site visits conducted by ASPR and CDC project officers to assess the activities, progress, and challenges of awardees and their subcontractors. Awardees shall maintain all program documentation that substantiates achievement of capabilities, performance measures, and other programmatic requirements, including all-hazards public health emergency preparedness and response plans, and make those documents available to ASPR and CDC staff, as requested, during site visits or through other requests. Awardees should plan on hosting site visits at least once every 12 to 18 months.

11. Submit pandemic influenza plans annually as required by Section 319C-1 and 319C-2 of the PHS Act and amended by PAHPA. ASPR and CDC will provide further information on the 2012 submission in a separate guidance document.

HPP Requirements

HPP cooperative agreement funds will be used to continue maintaining and refining medical surge capacity and capability at the state and local levels through associated planning, personnel, equipment, training, exercises, and healthcare coalition development. ASPR recognizes that maintenance and refinement of current capabilities and functions are critical for the sustainability of awardee preparedness efforts.

Awardees must complete and submit all required HPP funding application components, including project abstracts, project narratives, work plans, and budgets as outlined in Section IV, with an emphasis on short-term and long-term plans to address the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*; and complete and report on activities described in the application work plans.

Awardees must describe in either their funding application project narratives or capability plans the activities they plan to conduct to comply with the following requirements. Where applicable, the appropriate capability sections are listed with each requirement.

1. Address required resource elements. Awardees are expected to address all planning resource elements listed as required in each capability of the healthcare preparedness capabilities appendix. Resource elements indicated as "based on priorities and needs" should be assessed by the awardee or designee with determination for completion based on the priorities and needs of the targeted stakeholder. (See Appendix 4 for additional information on the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*. The complete document is available at http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.)

In addition to these requirements, and before funding additional activities based on the prioritization process, specific capability components must be fully addressed as described below.

2. Develop healthcare coalitions. Awardees are expected to develop or refine healthcare coalitions as outlined in Capability 1: Healthcare System Preparedness; Function 1: Develop, refine, and sustain healthcare coalitions; and in Capability 10: Medical Surge; Function 1: The healthcare coalition assists with the coordination of the healthcare organization response during incidents that require medical surge. (See Appendix 4.)

Staged development of healthcare coalitions is acceptable during the five-year project period. This staged approach is based on initial assessment of the capabilities and

functions to include the associated resource elements of Capability 1, Function 1. The following stages of healthcare coalition development will be used during this process with the first stage based on the assumption that the awardee has not met any of the requirements outlined in these healthcare coalition functions. Timelines for staged development will be determined as a collaborative process between awardees and their project officers.

Stage 1:

- Determine regional approach and boundaries
- Establish awardee support and partnership
- Determine governance structure
- Establish the healthcare coalition for purposes of preparedness through appropriate documentation

Stage 2:

- Maintain the above healthcare coalition Stage 1 requirements through sustainment and preparedness activities
- Perform preparedness activities as outlined in Capability 1: Healthcare System Preparedness

Stage 3:

- Determine how healthcare coalitions will address multiagency coordination during response and perform ongoing regional exercises to test this capability. Healthcare coalition multiagency coordination is outlined in Capability 3: Emergency Operations Coordination and Capability 10: Medical Surge.

The following must be addressed in Budget Period 1 funding applications and annual progress reports:

1. Awardees must provide in their funding application project narratives plans to assess the healthcare coalitions in their jurisdictions and to determine which stage of development their coalitions are in during Budget Period 1.
2. Awardees that consider their healthcare coalitions to be in Stage 2 must submit plans that outline strategies to meet Stage 3 requirements and be prepared to provide documentation of Stage 1 completion.
3. Awardees that consider their healthcare coalitions to be in Stage 3 must submit plans that outline strategies to continue sustainment and exercise planning to strengthen their coalitions and be prepared to provide documentation of Stage 1 and Stage 2 completion.

3. Identify existing healthcare coalitions. HPP awardees funded under this announcement must provide to ASPR basic information describing the extent of healthcare preparedness coalitions (hereafter referred to as coalitions) that currently exist within their states. Each awardee that anticipates receiving HPP funds for fiscal year 2012 is required to provide the following information as two separate attachments to their Budget Period 1 funding applications:

   - Attachment 1: The number of participating healthcare coalitions within the awardee's state working toward Capability 1: Healthcare System Preparedness. For each coalition, identify the:

- Coalition name;
- Coalition members by type (i.e., hospital, long-term care center, community health center), name, and national provider identification (NPI) number;
- Coalition stage of development;
- Coalition point of contact (POC) name;
- POC telephone number;
- POC street address;
- POC e-mail address; and
- Coalition Web site address (if one exists)

- Attachment 2: A map by zip code or county of the health service regional areas within the state that are covered by each coalition.

In partnership with each HPP awardee, all identified coalitions will complete a questionnaire to describe their characteristics and functions. ASPR will use this data to establish baseline information on existing coalitions. Results will be shared with the awardees.

4. Develop and implement healthcare system exercise and evaluation programs.

Exercise Program: Budget Period 1 HPP funding applications must address the evaluation of state and local preparedness and response capabilities through exercises.

Exercise Plans: Awardees must develop, refine, and submit a multiyear exercise plan for conducting **substate regional or statewide, functional or full-scale** exercises to test the ASPR healthcare preparedness capabilities. Local public health should be included in exercises that have healthcare participation based on the submitted exercise plans.

Within the exercise plan, awardees must:

- Delineate exercise location, dates, and how healthcare systems are involved;
- Describe the healthcare system role in multiple capabilities;
- Describe the lessons learned and next steps;
- Describe integration of training initiatives into exercises.

HPP awardees must ensure that all HPP participating hospitals participate in at least one substate regional or statewide Homeland Security Exercise and Evaluation Program (HSEEP)-based functional or full-scale exercise during the five-year project period.

Please see Appendix 11 for details on exercise-related evaluation and annual progress report requirements.

5. <u>Support training and education.</u>

Awardees will assess and report annually which participating healthcare organizations currently have adopted all NIMS implementation activities and which are still in the process of implementing the 11 activities. For any participating

healthcare organization still working to implement NIMS activities, funds must be prioritized and made available during HPP Budget Period 1 to ensure the full implementation and maintenance of all activities during the five-year project period.

Healthcare Organizations: All participating healthcare organizations must comprehensively track all NIMS implementation activities and report on those activities annually as part of the reporting requirements for this cooperative agreement.

The following information must be addressed and submitted as an attachment with the HPP Budget Period 1 funding applications (a data extraction of which is to be entered into the PERFORMS application module on NIMS requirements); an update of the inventory must be included in annual progress reports:

- A comprehensive inventory that lists participating healthcare organizations; identifies each of the 11 NIMS implementation activities that have been achieved; and identifies each activity still in progress;
- The comprehensive inventory must include each participating healthcare organization's respective national provider identification (NPI) number; and
- Detailed descriptions of all implementation activities with associated budget allocations, that ensure all healthcare organizations achieve and maintain all activities during Budget Period 1.

Gap-based Training

Awardees should ensure that education and training opportunities/programs exist for healthcare workers based on training needs to address gaps in capabilities and that are prioritized by awardees or their designees.

Awardees must undertake activities that ensure all education and training opportunities/programs enhance the ability of healthcare workers to respond in a coordinated manner that does not overlap with those from local health departments, community healthcare organizations, emergency response agencies, public safety agencies, and others. To reduce costs and build relationships, joint training of all healthcare organization workers is strongly encouraged.

For HPP awardees, funds may be used to support the cost of healthcare organization worker participation in training centered on capability development; to prepare workers with the necessary knowledge, skills, and abilities to perform/enhance the capability; and to participate in exercises on those capabilities or related systems.

Additionally, HPP awardees are expected to work closely with their subawardees in determining cost-sharing arrangements that will facilitate the maximum number of workers participating in training, and exercise activities.

The following must be addressed in HPP Budget Period 1 funding applications and annual progress reports:

- Describe how the education and training activities proposed in the awardees' program narrative support healthcare preparedness capabilities development and are linked to the healthcare organizations' community-based, regional or state HVAs and risk assessments;
- Describe how the knowledge, skills, and abilities acquired as a result of education and training activities proposed in the program narrative will be incorporated into exercises;
    - A summary of each HPP-funded education and training opportunity including the subject matter of all trainings and the number of healthcare workers trained by specialty.

6. Support interoperable communications. Awardees are required to equip, train, and exercise the use of communication devices within participating healthcare organizations to allow effective communication horizontally (with each other and healthcare coalitions), and vertically with emergency medical services, fire, law enforcement, and local and state public health agencies, as outlined in Capability 6: Information Sharing, Function 2: Develop, refine, and sustain redundant, interoperable communication systems. Interoperable communications are tested during functional exercise requirements as outlined in the exercise requirements in the HPP Requirements section.

7. Comply with HAvBED (National Hospital Available Beds for Emergencies and Disasters) standards. Awardees are required to maintain and refine an operational bed tracking, accountability/ availability system compatible with the HAvBED data standards and definitions. Systems must be maintained, refined, and adhere to all requirements and definitions included in this funding opportunity announcement, with the ongoing ability to submit required data to the HHS Secretary's Operations Center (HHS SOC) using one of the two following options:

   - Awardees may choose to use the HAvBED Web portal to manually enter the required data. Data are to be reported in a sub-state regional/delineated aggregate format by the state; therefore the state must have a system that collects the data from the participating healthcare systems, OR
   - Awardees may use existing systems to automatically transfer required data in a substate regional/delineated format to the HAvBED server using the HAvBED EDXL Communication Schema, found at https://havbedws.hhs.gov.

   Information and technical assistance will be provided to awardees on both options. Awardees are expected to report required data electronically and sustain the capability to report hospital-level information in real time.

   Awardees are required to:

   - Within the state HAvBED system, be able to immediately (within 30 minutes) update reporting systems to include all data elements developed through ASPR in

fiscal year 2012 and be amenable to the addition or removal of data elements requested by ASPR.

- Ensure that the state emergency operations center can electronically report available and staffed beds according to HAvBED definitions by substate regions to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current grant year. These reports should reflect bed data from at least 75% of participating healthcare organizations in the state. (See Appendix 8 - HPP Benchmarks.)
- Participate in online webinars/trainings twice annually. These trainings will be made available on the homepage of the HAvBED Web site.
- Participate in the assessments of situational awareness tools, gaps in situational awareness data, and emerging needs. Awardees are encouraged to share situational awareness data elements, captured in their states, with neighboring states and the HAvBED Program.
- Participate in a minimum of one annual HAvBED drill/exercise, designed to test awardees' ability to meet the associated performance measures. Awardees will be notified of logistical details by the HAvBED systems manager prior to the drill/exercise. A report summary will be disseminated to awardees following the completion of the drill/exercise.
- Provide feedback to ASPR regarding how their states' healthcare coalitions could use HAvBED to support the healthcare preparedness capabilities.

HAvBED Web Portal Link: https://havbed.hhs.gov.

8. Describe specialized preparedness activities. As part of their data collection for annual progress reports, HPP awardees must provide brief narratives with approximate funding amounts describing any preparedness activities that occurred during the budget period benefitting the following groups:
    - At-risk individuals
    - Mental/behavioral healthcare facilities and providers
    - Emergency medical services
    - Trauma centers
    - Burn care centers
    - Community health centers
    - Long-term care facilities
    - Tribes
    - Pediatrics
    - Radiologic/nuclear preparedness programs
    - Poison control centers

PHEP Requirements

Awardees must complete and submit all required Budget Period 1 funding application components, including project abstracts, project narratives, work plans, and budgets as outlined in Section IV. The emphasis must be on short-term and long-term plans to address the *Public Health Preparedness Capabilities: National Standards for State and*

Local Planning. In addition, awardees must complete and report on planned activities described in the work plans submitted as part of the funding applications.

Awardees must describe in either the project narratives or capability plans included in their funding applications the activities they plan to conduct to comply with the following requirements. Where applicable, the appropriate capability sections are listed with each requirement.

1. Describe planned activities for resource elements. Awardees must describe in the capabilities plan any planned activities for those resource elements, including priority resource elements that will be addressed in Budget Period 1. While awardee reporting on priority resource elements in Budget Period 1 is only required for those resource elements with planned activities, CDC expects that most of the priority resource elements will have planned activities if they are associated with a capability the awardee is addressing during Budget Period 1. Priority resource element activities should have measurable outputs linked to program objectives and outcomes.

2. Seek local health department and tribal concurrence *(applicable to decentralized state health departments and those with federally recognized tribes).* Describe, as applicable, the process used to consult with local public health departments and American Indian/Alaska Native tribes within the jurisdiction to reach consensus, approval, or concurrence on approaches and priorities described in funding applications. (See Section IV, Project Narrative.)

3. Engage the state office on aging or equivalent office in addressing the public health emergency preparedness, response, and recovery needs of older adults. (See Appendix 5: Community Preparedness capability, Function 2: Build community partnerships to support health preparedness; and Community Recovery capability, Function 1: Identify and monitor public health, medical, and mental/behavioral health system recovery needs.)

4. Meet National Incident Management System (NIMS) compliance requirements. (See Appendix 5: Emergency Operations Coordination capability, Function 1: Conduct preliminary assessment to determine need for public activation.)

5. Develop preparedness and response strategies and capabilities that address the public health, mental/behavioral health, and medical needs of at-risk individuals in the event of a public health emergency. (See Appendix 5: Community Preparedness, Community Recovery, Emergency Public Information and Warning, Mass Care, Medical Surge, and Public Health Surveillance and Epidemiological Investigation capabilities.)

6. Utilize Emergency Management Assistance Compact (EMAC) or other mutual aid agreements for medical and public health mutual aid. (See Appendix 5: Emergency Operations Coordination capability.)

7. Coordinate with cross-cutting public health preparedness programs. PHEP program components as a whole should complement and be coordinated with other public health and healthcare programs as applicable. For example, some functions within the Public Health Laboratory, Public Health Surveillance and Epidemiological Investigation and Information Sharing capabilities may mutually support recipient activities as described within CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. In addition, PHEP awardees should work with immunization programs and partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response.

8. Conduct and document at least one annual preparedness exercise, which can include a tabletop exercise, a drill, a functional exercise, or a full-scale exercise, to test preparedness and response capabilities. Following such exercises, report identified strengths and weaknesses and corrective actions taken to address material weaknesses. CDC encourages awardees to exercise all preparedness capabilities; however, annual drills conducted to meet CDC's medical countermeasure distribution and dispensing (MCMDD) composite score can satisfy this requirement. See the exercise planning requirement in the Joint HPP-PHEP Requirements section.

9. Assure compliance with the following requirements. Unless otherwise noted, no specific narrative response or attachment is necessary as CDC's Procurement and

Grants Office (PGO) considers that acceptance of the Budget Period 1 funding awards constitutes assurance of compliance with these requirements.

- Maintain a current all-hazards public health emergency preparedness and response plan and submit to CDC when requested and make available for review during site visits.
- Submit required progress reports and program and financial data, including progress in achieving evidence-based benchmarks and objective standards; performance measures data including data from local health departments; the outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions; accomplishments highlighting the impact and value of the PHEP program in their jurisdictions; and descriptions of incidents requiring activation of the emergency operations center and Incident Command System. Reports must describe:
    - preparedness activities that were conducted with PHEP funds;
    - purposes for which PHEP funds were spent and the recipients of the funds;
    - the extent to which stated goals and objectives as outlined in awardee work plans have been met; and
    - the extent to which funds were expended consistent with the awardee funding applications. (See Section VI.)
- In coordination with the Hospital Preparedness Program, inform and educate hospitals and healthcare coalitions within the jurisdiction on their role in public health emergency preparedness and response. (See Appendix 5: Medical Surge capability, Function 1: Assess the nature and scope of the incident.)

- Submit an independent audit report every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.
- Have in place fiscal and programmatic systems to document accountability and improvement.
- Provide CDC with situational awareness data generated through interoperable networks of electronic data systems. (See Appendix 5: Information Sharing capability.)

Please note the following two annual requirements apply only to those awardees funded for these activities.

10. Comply with Cities Readiness Initiative (CRI) guidelines. To align with the PHEP cooperative agreement's capabilities-based approach, CRI requirements support the Medical Countermeasure Dispensing and the Medical Materiel Management and Distribution capabilities. As described in those capabilities, CRI supports medical countermeasure distribution and dispensing (MCMDD) for all-hazards events, which includes the ability of jurisdictions to develop capabilities for "U.S. cities to respond to a large-scale biologic attack, with anthrax as the primary threat consideration." This is a change from previous guidance documents in that the CRI scenario planning was specific to an anthrax scenario only. CDC recognizes that jurisdictions need to improve all-hazards planning capabilities and has broadened the CRI criteria to support this activity.

CDC has developed a MCMDD composite score to serve as a collective indicator of MCMDD preparedness and operational capability within local/planning jurisdictions, CRI areas, states, directly funded cities, territories, and freely associated states. Local, city, state, and territorial preparedness will be subsequently defined as a composite measure derived from results of technical assistance reviews (TARs), drill submissions, full-scale exercise, and compliance with programmatic standards. Budget Period 1 is the second year of the five-year MCMDD composite score framework, which was introduced in Budget Period 11 of CDC-RFA-TP11-1101. Within this framework, awardee requirements are modified annually to coincide with the progression of the five-year framework. (See Appendix 5: Medical Countermeasure Dispensing and Medical Materiel Management and Distribution capabilities.)

11. Continue Level 1 chemical laboratory surge capacity activities. The 10 awardees must address objectives related to chemical emergency response surge capacity as outlined in the Public Health Laboratory Testing capability, including staffing and equipping the lab, maintaining critical instrumentation in a state of readiness, training and proficiency testing for staff, and participating in local, state, and national exercises. In addition, awardees must describe how they plan to increase their laboratory capabilities and capacities consistent with the Laboratory Response Network for chemical terrorism program objectives, including the addition of new high-throughput sample preparation and analysis techniques and analytical capability for new threat

agents. (See Appendix 5: Public Health Laboratory Testing capability, Function 3: Conduct testing and analysis for routine and surge capacity.)

CDC will provide additional guidance on PHEP requirements for the territories of American Samoa, Commonwealth of the Northern Marina Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, Republic of Palau, and U.S. Virgin Islands.

Evaluation and Performance Measurement

Awardee performance reporting provides critical information needed to evaluate how well HPP and PHEP funding has improved the nation's ability to prepare for and respond to public health emergencies. ASPR and CDC use this information to assess public health and healthcare system capacity and operational capabilities, identify gaps and areas needing improvement, develop technical assistance and other training to support awardee needs, and report to Congress and the public on the impact of the funding. Performance measures are derived directly from ASPR's *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (see Appendices 4 and 5).

Performance measures are a key tool used to determine program effectiveness and may focus on any level of the public health or healthcare system deemed to be most important to understanding the particular public health or healthcare preparedness capability being

assessed, namely, at the awardee (e.g., state, directly funded locality, territory) or subawardee level. Subawardees include, but are not limited to, local health departments, public health laboratories, healthcare coalitions, healthcare organizations, and others supported by HPP or PHEP funds.

Reporting Requirements

The 62 HPP and PHEP awardees are the entities required to report performance measures and related evaluation and assessment data to ASPR and CDC. Awardees are responsible for the collection of information from their own programs and awardee-level partners, as well as from local health departments, healthcare coalitions, and other entities supported by HPP or PHEP. Select performance measures may also require that awardees report critical preparedness-related information on nonparticipating entities.

Fiscal year 2012 performance measures include those that are specific to HPP, specific to PHEP, and a new subset of performance measures jointly developed by ASPR and CDC, which will be used to satisfy the requirements of both programs. All awardees must report on performance measures along with their supporting data elements for Budget Period 1. In general, HPP awardees are required to report at least annually on all measures specific to the HPP program; PHEP performance measures data need only be reported by those awardees as detailed in Appendix 9. Both HPP and PHEP awardees are required to report at least annually on the HPP-PHEP measures. In addition, at the request of ASPR or CDC, awardees of either or both programs shall report a limited amount of (additional) specific performance and other evaluation and assessment-related

information at the end of the budget period in annual progress reports, based on real incidents occurring in awardee jurisdictions.

Detailed guidance on performance measures implementation is available at http.phe.gov/preparedness/planning/evaluation.

ASPR and CDC may modify performance measures, other evaluation and assessment methods, and data collection requirements on an annual basis, or as needed, in accordance with their respective directives, goals, and objectives, or as performance measures or other evaluation methods are developed and refined.

Throughout Budget Period 1, all measures (HPP, PHEP, and HPP-PHEP measures) not previously utilized by either program in prior budget periods (i.e., newly introduced measures) will be considered provisional, meaning that awardees will be required to report these data, but performance criteria will not be enforced and public dissemination of data by ASPR and CDC will be withheld to the extent possible under federal law. Performance and other data collected on the HPP-specific, the HPP-PHEP, and select PHEP-specific measures will be used by ASPR and CDC in conducting a national pilot study to determine the need for further refinements to the measures based on real-world experience and data.

To conduct this pilot test, the performance and other data on all the HPP and HPP-PHEP performance measures will be collected from HPP and PHEP awardees during both the

mid-year (January 31, 2013) and the end-of-year (September 30, 2013) reporting cycles for Budget Period 1. Select provisional PHEP measures may also be collected at the mid-year and the end-of-year reporting cycles for pilot testing purposes. Existing (not provisional) PHEP measures will be collected during the end-of-year reporting cycle. The performance data collected at mid-year will serve as the basis for analysis so that the final set of performance measures and data elements can be identified for all awardees for Budget Period 2 and thereafter.

HPP, PHEP, and HPP-PHEP Performance Measures

All fiscal year 2012 performance measures can be found in the following appendices:

- HPP-PHEP Performance Measures: Appendix 6
- HPP Performance Measures: Appendix 7
- PHEP Performance Measures: Appendix 9

Applicability of PHEP Performance Measures

Appendix 9 describes the specific performance measurement reporting requirements for PHEP awardees, as well as which measures are optional. To reduce reporting burden, CDC may provide the option for awardees to report data for select performance measures from a sample of counties within awardee jurisdictions (as opposed to reporting data from all counties or all local health departments). Additional guidance will be provided to assist PHEP awardees in implementing data collection and reporting for these measures.

Evidence-based Benchmarks

ASPR and CDC have specified a subset of measures and select program requirements as benchmarks as mandated by Sections 319C-1 and 319C-2 of the PHS Act as amended by PAHPA. To substantially meet a benchmark, awardees must provide complete and accurate information describing how the benchmark was met.

PAHPA Accountability Provisions

Awardees that fail to "substantially meet" the benchmarks required by this funding opportunity announcement are subject to withholding of a statutorily mandated percentage of the award if an awardee fails substantially to meet established benchmarks for the immediately preceding fiscal year or fails to submit a satisfactory pandemic influenza plan.

HHS is required to treat each failure to substantially meet all the benchmarks and each failure to submit a satisfactory pandemic influenza plan as a separate withholding action. For example, an awardee failing substantially to meet benchmarks AND who fails to submit a satisfactory pandemic influenza plan could have 10% withheld for each failure for a total of 20% for the first year this happens. If this situation remained unchanged, HHS would then be required to assess 15% for each failure for a total of 30% for the second year this happens. Alternatively, if one of the two failures is corrected in the second year but one remained, HHS is required to withhold 15% of the second year funding.

ASPR and CDC expect awardees to achieve, maintain, and report on benchmarks throughout the five-year project period. Data for HPP benchmarks are required to be submitted to ASPR no later than January 31, 2013, as part of the mid-year progress report. Submission dates for PHEP benchmark data will be provided in additional guidance, but data will not be required sooner than January 31, 2013. Note that a key benchmark for both programs, "demonstrated adherence to application and reporting deadlines," requires timely submission of applicable information throughout Budget Period 1 – not just at mid-year. HPP and PHEP benchmarks can be found in Appendices 8 and 10.

ASPR and CDC reserve the right to classify performance measures or other HPP or PHEP program requirements as benchmarks subject to the applicable withholding provisions on an annual basis in accordance with PAHPA as well as ASPR and CDC directives, goals, and objectives. ASPR and CDC intend to publish these benchmarks annually as part of the continuation funding application process. Awardees shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to ASPR and CDC staff, as requested, during site visits or through other requests.

Enforcement Actions and Disputes

HPP and PHEP awardees that fail substantially to meet benchmarks for the immediately preceding fiscal year or who fail to submit pandemic influenza plans as part of their applications for HPP and PHEP funds may have funds withheld from their awards. An

awardee that fails to correct such noncompliance shall be subject to withholding in the following amounts:

- For the fiscal year immediately following a fiscal year in which the awardee has failed substantially to meet performance measures/benchmarks or who has failed to submit a satisfactory pandemic influenza plan; an amount equal to 10 percent of funding the awardee was eligible to receive.
- For the fiscal year immediately following two consecutive fiscal years in which an awardee experienced such a failure, an amount equal to 15 percent of funding the awardee was eligible to receive, taking into account the withholding of funds for the immediately preceding fiscal year.
- For the fiscal year immediately following three consecutive fiscal years in which an awardee experienced such a failure, an amount equal to 20 percent of funding the awardee was eligible to receive, taking into account the withholding of funds for the immediately preceding fiscal years.
- For the fiscal year immediately following four consecutive fiscal years in which an entity experienced such a failure, an amount equal to 25 percent of funding the awardee was eligible to receive for such a fiscal year, taking into account the withholding of funds for the immediately preceding fiscal year.

ASPR and CDC Support to Awardees

In a cooperative agreement, ASPR and CDC staff members are substantially involved in program activities, above and beyond routine grant monitoring. This section outlines ASPR and CDC support of awardees.

Monitoring Performance

- Monitoring adherence to all relevant Public Health Service, HHS, ASPR, and CDC rules, regulations and policies regarding cooperative agreements

Technical Assistance Planning and Consultation

ASPR and CDC project officers will actively work with HPP and PHEP awardees to develop individualized technical assistance plans using a standardized format and process. The plans will focus on technical assistance needs identified jointly by awardees and project officers, as well as strategies for addressing those needs. Technical assistance plans will be monitored on a regular basis and updated by project officers and awardees as part of the mid-year review process. Additional information will be provided by program staff. Technical assistance can be provided on a variety of issues, including but not limited to:

- Integration/coordination of federal funding for preparedness
- Facilitating access to ASPR and CDC preparedness subject matter experts (e.g. medical surge, volunteer management, laboratory testing, epidemiology and surveillance, and environmental health)
- Translating promising/useful practices for dissemination to the field
- Providing technical assistance on achievement of performance measures and benchmarks
- Providing guidance on demonstrating achievement of capabilities and using quality improvement-focused processes to document the process

- Cooperative agreement fiscal management

Joint Site Visits

It is necessary for HPP and PHEP project officers to conduct routine site visits to assess the activities, including progress and challenges, of awardees and their subawardees and to provide technical assistance. Awardees should plan on hosting site visits at least once every 12 months to 18 months. HPP and PHEP site visits should be coordinated with ASPR's regional emergency coordinators (RECs) and conducted jointly whenever possible. Awardees should be actively involved in the planning and execution of site visits and make available all program documentation that substantiates achievement of capabilities and other programmatic requirements, including all-hazards public health emergency preparedness and response plans.

Training Opportunities

Participation in ASPR- and CDC-sponsored training, workshops, and meetings is essential to the effective implementation of the HPP-PHEP cooperative agreements. ASPR and CDC project officers will work with awardees to help obtain supporting documentation to ensure participation at mandatory conferences and training workshops. Annual HPP and PHEP budgets should include travel for appropriate HPP and PHEP staff to attend HPP- and PHEP-required meetings and training workshops, including regional meetings.

- Mandatory Joint Meeting Requirements
    - Annual Public Health Preparedness Summit sponsored by NACCHO

- Annual joint HPP-PHEP preparedness conference sponsored by ASPR and CDC
- Directors of Public Health Preparedness annual meeting sponsored by ASTHO

In addition, ASPR requires:

- HPP Performance Measurement Training sponsored by ASPR (to be held in summer of 2012)

Key HPP and PHEP staff also are encouraged to participate in other national and regional conferences, meetings, and training workshops related to public health preparedness to more effectively manage cooperative agreement activities. These include but are not limited to the Integrated Training Summit sponsored by the National Disaster Medical System; the CDC Strategic National Stockpile annual conference; pandemic influenza planning conferences; various nuclear/radiological training opportunities such as the National Radiological Emergency Preparedness (NREP) Conference and the Conference of Radiation Control Program Directors (CRCPD) annual meetings; Council of State and Territorial Epidemiologists (CSTE) meetings; Association for Public Health Laboratories (APHL) annual conferences and trainings required to maintain laboratory proficiency; border health security national and regional conferences; and Public Health Information Network (PHIN) annual conferences and trainings.

Section II. Award Information

Type of Award: Cooperative agreement (CA) .

Award Mechanism

U90: Cooperative Agreements for Special Projects of National Significance

Fiscal Year 2012 Funding

Hospital Preparedness Program: $351,644,731

Public Health Emergency Preparedness Program: $619,447,806

Approximate Total Project Period Funding

Subject to availability of funds

Number of Awards: 62 awardees

- States: 50
- Localities: (4) Chicago, Los Angeles County, New York City, and Washington, D.C.
- Territories and Freely Associated States: (8) Puerto Rico, U.S. Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia

Approximate Average Award

PHEP: Approximately $10 million (Includes direct and indirect costs.)

HPP: Approximately $5.7 million (Includes direct and indirect costs.)

These amounts are for the first 12-month budget period and include both direct and indirect costs.

Floor of Individual Award Range

HPP

- 50 states and Puerto Rico: $500,000
- 4 localities: $500,000
- 7 territories and freely associated states: $250,000

PHEP

- 50 states and Puerto Rico: $4 million
- 4 localities: $5 million
- 7 territories and freely associated states: $300,000

Ceiling of Individual Award Range: None

Anticipated Award Date: July 1, 2012

Budget Period Length: 12 months

Project Period Length: 5 years

Continuation Funding

Throughout the project period, ASPR and CDC commitment to continuation of awards in subsequent budget periods will be conditioned on the availability of funds, evidence of satisfactory progress by awardees (as documented in required reports), and the determination that continued funding is in the best interest of the federal government.

Use of Funds for Response

HPP

Section 319C-2 of the PHS Act authorizes the HHS Secretary to award grants in the form of cooperative agreements to enable eligible entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. As awardees expend funds to meet the applicable goals outlined in section 2802(b) of the PHS Act, in general HPP funds are to be used only for activities which prepare for public health emergencies and improve surge capacity – consistent with approved spend plans. However, under certain conditions, HPP state staff may request to change the scope of work and include a response activity as one of the required exercise components.

Awardees should contact their assigned HPP project officers and grants management specialists for guidance on the process to effect such a change. The request to use an actual response for an exercise will be considered for approval under these conditions: a state declaration of an emergency, disaster, or public health emergency in the affected area, a request to support staff salary for no longer than 96 hours after the event, there is a lack of other appropriate funds to offset the proposed costs (i.e salary), and the awardee agrees to submit within 60 days after the event an after-action report and corrective action plan. Upon receipt of this information ASPR will review the documents and issue a final determination as to the disposition of the request.

Surge Capacity – Surge Capability

HPP's primary focus continues to be medical surge capacity, which can be broadly defined as the ability of a healthcare entity to adequately care for increased numbers of patients. In Budget Period 1, HPP is addressing medical surge through the development of eight healthcare preparedness capabilities which will assist healthcare systems in preparing to prevent, protect, respond to, and recover from the effects of a disaster. Specifically related to Capability 10: Medical Surge, a planning target is assigned for healthcare organizations to meet surge requirements as follows:

> "The percent of healthcare coalitions that have a coordinated mechanism in place to provide an appropriate level of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients) that includes providing bed availability for 20% above the daily census within 4 hours of a disaster."

PHEP

PHEP cooperative agreement funding is intended primarily to support preparedness activities that help ensure state and local public health departments are prepared to prevent, detect, respond to, mitigate, and recover from a variety of public health threats. The PHEP cooperative agreement provides technical assistance and resources that strengthen public health preparedness and enhance the capabilities of state and local governments to respond to these threats. PHEP funds may, on a limited, case-by-case basis, be reallocated to support response activities to the extent they are used for the purposes provided for in Section 319C-1 of the PHS Act (the program's authorizing

statute), applicable cost principles, the funding opportunity announcement, and the awardee's application (including the jurisdiction's all-hazards plan). Awardees must receive approval from CDC before using PHEP funds for response.

Funding Formula

The distribution of HPP and PHEP funds is calculated using a formula established by the HHS Secretary that includes a base amount for each awardee plus population-based funding. The base portion is allocated in the following manner.

HPP Base

- 50 states, Puerto Rico, and four localities (Chicago, Los Angeles County, New York City, and Washington, D.C.) - $500,000
- 7 U.S. territories and freely associated states - $250,000

PHEP Base

- 50 states and Puerto Rico - $3 million each
- 4 localities (Chicago, Los Angeles County, New York City, and Washington, D.C.) - $5 million each
- 7 U.S. territories and freely associated states - $300,000 each

HPP and PHEP awardees receive population-based funding equal to their proportional share of the national population as reflected in recent U.S. Census population estimates. The population-based funding is calculated using the available pool of funds remaining

after the base funding and other applicable funding allocations are carved out of the total HPP and PHEP allocations. For Budget Period 1, 2010 U.S. Census data were used to calculate the population-based funding.

For PHEP awardees whose base-plus-population PHEP funding would be less than the funding floor or minimum award, their awards were adjusted to ensure they receive the minimum base-plus-population funding amount.

HPP Funding

A total of $351,644,731 is currently available for Budget Period 1. The majority of HPP funds (ideally 75% or more), should be distributed to facilitate maintenance of the healthcare capabilities, to build state and community preparedness, and to benefit eligible healthcare entities. Awardees should work with subawardees to develop deliverables that clearly integrate and enhance their healthcare system preparedness activities, with the overall effect of making the systems function in a more efficient, resilient, and coordinated manner.

PHEP Funding

A total of $619,447,806 is currently available for Budget Period 1. In addition to base-plus-population funding, PHEP funding is awarded for specific preparedness activities under the significant unmet needs provision in 319C-1(i)(5) of the PHS Act. The funding amounts available for the categories below are shown in Appendices 2 and 3.

Cities Readiness Initiative (CRI)

All 50 states receive CRI funding using a population-based calculation. The Budget Period 1 funding formula is calculated using a per capita of $0.286594573 based on the U.S. Census 2010 population estimates with the following exceptions:

1. PHEP jurisdictions that would have received less than $169,600 based on the Budget Period 1 formula were increased to $169,600.
2. Directly funded cities were awarded the same amount they received for fiscal year 2011.

For state awardees, 75% of their allocated CRI funds must be provided to CRI jurisdictions in support of all-hazards MCMDD planning and preparedness. CRI jurisdictions are defined to include independent planning jurisdictions (as defined by the state and locality) that include those counties and municipalities within the defined metropolitan statistical area (MSA) or the New England County Metropolitan Areas (NECMAs).

- Level 1 Chemical Laboratory Surge Capacity

  Ten states (California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin) are eligible to receive funding to support Level 1 chemical laboratory surge capacity personnel, equipment, and activities.

Section III. Eligibility Information

Eligible Applicants

Eligible applicants for this funding opportunity announcement are limited to those currently funded under the Hospital Preparedness Program (HPP) cooperative agreement and the Public Health Emergency Preparedness (PHEP) cooperative agreement CDC-RFA-TP11-1101. As defined in sections 319C-1 and 319C-2 of the PHS Act, eligible applicants for this funding opportunity are states, a consortium of states, or eligible political subdivisions that prepare and submit a sufficient application compliant with the statutory and administrative requirements described in this document. For the purposes of this announcement, the term "state" may include a state, territory, or freely associated state.

Required Registrations

Registering your organization through www.grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the "Get Registered" screen of www.grants.gov. Please visit www.grants.gov at least 30 days prior to submitting your application to familiarize yourself with the registration and submission processes. The registration process will take three to five days to complete. However, the Grants.gov registration process also requires that you register your organization with the Central Contractor Registry (CCR). The CCR registration can require an additional one to two days to complete. You are required to maintain a current registration in CCR.

Central Contractor Registration and Universal Identifier Requirements

Foreign entities only: Prior to registering for CCR, please follow the Special Instructions for acquiring a Commercial and Governmental Entity (NCAGE) Code: http://www.dlis.dla.mil/Forms/Form_AC135.asp

All applicant organizations **must obtain** a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An authorized organizational representative (AOR) should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the US D&B D-U-N-S Number Request Form or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note this is an organizational number. Individual Program Directors/Principal Investigators do not need to register for a DUNS number.

Additionally, all applicant organizations must register in the Central Contractor Registry (CCR) and maintain the registration with current information at all times during which it has an application under consideration for funding by CDC and, if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at www.ccr.gov .

If an award is granted, the grantee organization must notify potential subawardees that no organization may receive a subaward under the grant unless the organization has provided its DUNS number to the grantee organization.

Cost Sharing or Matching

ASPR and CDC may not award a cooperative agreement to a state or consortium of states under these programs unless the awardee agrees that, with respect to the amount of the cooperative agreements awarded by ASPR and CDC, the state will make available nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award.

Match may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government may not be included in determining the amount of such nonfederal contributions.

Please refer to 45 CFR § 92.24 for match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in the Budget Period 1 application for funds, follow procedures for generally accepted accounting practices, and meet audit requirements.

Exceptions to Matching Funds Requirement

- The match requirement does not apply to the political subdivisions of New York City, Los Angeles County, or Chicago.
- Pursuant to department grants policy implementing 48 U.S.C. 1469a(d), any required matching (including in-kind contributions) of less than $200,000 is waived with respect to cooperative agreements to the governments of American Samoa, Guam, the Virgin Islands, or the Northern Mariana Islands (other than those consolidated under other provisions of 48 U.S.C. 1469). For instance, if 10% (the match requirement) of the award is less than $200,000, then the entire match requirement is waived. If 10% of the award is greater than $200,000, then the first $200,000 is waived, and the rest must be paid as match.

Matching does not apply to future contingent emergency response awards that may be authorized under 317(a) and 317(d) of the Public Health Service Act unless such a requirement were imposed by statute or administrative process at the time.

Maintenance of Funding (MOF)[2]

Awardees must maintain expenditures for healthcare preparedness and public health security at a level that is not less than the average level of such expenditures maintained by the awardee for the preceding two-year period. This represents an awardee's historical level of contributions or expenditures (money spent) related to federal programmatic activities that have been made prior to the receipt of federal funds. The MOF is used as

[2]This funding opportunity announcement uses one term that applies to both maintenance of funding (MOF) and maintaining state funding (MSF). Section 319C-1 requires PHEP awardees to maintain expenditures for public health security. Section 319C-2 requires HPP awardees to maintain expenditures for healthcare preparedness. This provision addresses both requirements.

an indicator of nonfederal support for public health security and healthcare preparedness before the infusion of federal funds. These expenditures are calculated by the awardee without reference to any federal funding that also may have contributed to such programmatic activities in the past. The definition of eligible state expenditures for public health security and healthcare preparedness includes:

- Appropriations specifically designed to support healthcare or public health emergency preparedness as expended by the entity receiving the award; and
- Funds not specifically appropriated for healthcare or public health emergency preparedness activities but which support healthcare or public health emergency preparedness activities, such as personnel assigned to healthcare or public health emergency preparedness responsibilities or supplies or equipment purchased for healthcare or public health emergency preparedness from general funds or other lines within the operating budget of the entity receiving the award.

Awardees must stipulate the total dollar amount in their cooperative agreement funding applications. Awardees must be able to account for MOF separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MOF may not include any subawardee matching funds requirement where applicable.

MOF does not apply to future contingent emergency response awards that may be authorized under 317(a) and 317(d) of the Public Health Service Act unless such a requirement were imposed by statute or administrative process at the time.

Maximum Amount of Carry-over Funds

PAHPA requires the HHS Secretary to determine the maximum amount of unobligated funds that can be carried over into each succeeding budget period. Awardees must repay any funds that exceed the maximum percentage of an award that may be carried over to the succeeding fiscal year.

Section IV. Application and Submission Information

Submission Dates and Times

This announcement is the definitive guide on application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review, and the applicant will be notified the application did not meet the submission requirements

Application Deadline: ***May 01, 2012*** on Grants.gov by 11:59 p.m. U.S. Eastern Time, 60 calendar days after posting of the original FOA on www.grants.gov.

Awardees must download the SF-424 application package associated with this funding opportunity from www.grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms online, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS)

staff at (770) 488-2700 email:pgotim@cdc.gov Monday-Friday 7 a.m. to 4:30 a.m. U.S. Eastern Standard Time for further instruction. CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all federal holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by e-mail at support@grants.gov. Submissions sent by e-mail, fax, CDs or thumb drives of applications will not be accepted.

Content and Form of Application Submission

All applicants are required to sign and submit CDC Assurances and Certifications that can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm. Print, scan, and upload as an additional attachment into the application package.

A letter of intent is not applicable to this funding opportunity announcement.

Application Requirements

The mandatory SF-424 application package associated with this funding opportunity includes:

- Application for Federal Assistance (SF-424);
- Disclosure of Lobbying Activities (SF-LLL);
- HHS Checklist Form PHS-5161;
- Budget Information for Non-Construction Programs (SF-424A);
- Budget Narrative Attachment Form (Budget Justification);
- Project Abstract Summary;
- Project Narrative Attachment Form; and
- Other Attachments Forms (1 each unless otherwise noted)
    - Attachment A: Indirect Cost Rate Agreement (one each for HPP and PHEP)
    - Attachment B: Work Plan (one each for HPP and PHEP)
    - Attachment C: Additional SF-424A
    - Attachment D: Budget Narrative Attachment Form (Budget Justification)
    - Attachment E: Additional Project Abstract Summary
    - Attachment F: Additional Project Narrative
    - Attachment G: Healthcare Coalition Information (HPP only)
    - Attachment H: Healthcare Coalition Map (HPP only)
    - Attachment I: Exercise Plan (HPP Only)
    - Attachment J: Training Plan (HPP Only)
    - Attachment K: Local Concurrence Letters (applicable PHEP awardees)

- Attachment L: Tribal Concurrence Letters (applicable PHEP awardees only)
- Attachment M: CDC Assurances and Certifications

HPP and PHEP Submission Requirements

The HPP-PHEP funding application requires submission of a joint application containing the following information via www.grants.gov:

- Project abstract (one each for HPP and PHEP)
- Project narrative (one each for HPP and PHEP)
- Work plan (one each for HPP and PHEP)
- Itemized budget (one each for HPP and PHEP)

Project Abstract

A project abstract must be completed as part of the grants.gov application forms and should be no longer than two pages. The abstract must contain a high-level summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

Project Narrative

The narrative should summarize the overall preparedness strategy for the five-year project period, as well as describe specific plans for capabilities to be addressed during Budget Period 1. In addition, the project narrative should briefly address any challenges or barriers that could affect the ability to make progress on the healthcare or public health preparedness capabilities and plans for addressing these issues. These should directly relate to activities that will be described in work plans for Budget Period 1.

The project narrative must be uploaded in a PDF file format when submitting via www.grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 25. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman
- Single spaced
- Page margin size: 1 inch
- Number all narrative pages; not to exceed the maximum number of pages.
- Application attachments must be in PDF format

1. Administrative Preparedness Strategies

   HPP and PHEP awardees should describe plans to effectively receive, use, and manage federal HPP and PHEP funds consistent with the purpose of the HPP and PHEP cooperative agreements, which is to achieve the capabilities needed to effectively respond to public health emergencies. Plans should ensure that

administrative activity (e.g., hiring, contracting, procurement, collaboration, etc.) is implemented with rigorous tracking and oversight to avoid delays and reduce the potential for inadequate responses and unobligated funds remaining at the end of the budget and project periods. Plans must include a projected timeline for the issuance of the awarded funds to subawardees. This timeline will be used to monitor the progress made in allocating funds to subawardees.

2. Description of Awardee Organization

Awardees must define their jurisdictions and the preparedness structure in their states as a whole including a high-level description of preparedness partners such as emergency management, law enforcement, behavioral health, and faith-based organizations for example. In addition, awardees should describe how the ESF #8 functions are organized in their jurisdictions, highlighting the current public health preparedness and healthcare preparedness structure. Awardees should also describe the coordination of HPP and PHEP activities, how these programs are funded and their collaboration with emergency management and emergency medical service grant programs. Also, awardees must describe the jurisdiction's public health system (e.g., centralized, decentralized, or a combination of both). Lastly, awardees should outline Budget Period 1 plans to foster closer alignment of HPP and PHEP activities and potential challenges that may impede closer alignment.

3. Five-year Forecast

   Awardees must summarize and forecast their overall preparedness strategy for the five-year project period, taking into consideration the operational needs of the jurisdiction, the awardee's self-identified public health and healthcare preparedness program gaps, and the overarching guidance of the public health and healthcare preparedness capabilities. This forecast should represent a five-year, phased plan for completing the preparedness program work associated with the public health and healthcare capabilities and should reflect awardee strategic priorities, available resources, and any anticipated challenges or barriers that may affect the ability to complete or make progress on the capabilities. Specifically, the forecast must include detailed plans for capabilities to be addressed during Budget Period 1 and an indication of when work on the remaining capabilities will be conducted during the remaining project period. For example, if an awardee does not plan to deliberately work on the fatality management capability until year three or four that should be reflected in the preparedness strategy and forecast.

4. Preparedness Accomplishments and Program Impact

   Awardees should provide three to five accomplishments highlighting the impact of the HPP and PHEP programs in their jurisdictions to date. If possible, these accomplishments should align with the public health and healthcare preparedness capabilities as outlined in the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* guidance documents.

Awardees should also highlight positive preparedness improvements resulting from program development.

5. Advisory Committee Activities

   Awardees must describe plans for establishing and maintaining a senior advisory committee or an equivalent entity. Comprised of senior officials (from governmental and nongovernment organizations), the advisory committee should enhance the integration of disciplines involved in homeland security, healthcare, public health, behavioral health, emergency management and emergency medical services, as well as integrate preparedness efforts across the jurisdiction and leverage funding streams. Awardees should also describe whether their advisory committees include citizen representation, including those representing at-risk individuals, to obtain public input and comment on emergency preparedness planning.

6. Healthcare Coalition Assessment (HPP awardees only)

   Awardees must describe their plans to assess each of the healthcare coalitions in their jurisdictions to determine which stage of development the coalitions are in during Budget Period 1. Awardees that consider their healthcare coalitions to be in Stage 2 must outline strategies to meet Stage 3 requirements and be prepared to provide documentation of Stage 1 completion. Awardees that consider their healthcare coalitions to be in Stage 3 must outline strategies to continue sustainment and exercise planning to strengthen their coalitions and be prepared to provide documentation of Stage 1 and Stage 2 completion.

7. Local Health Department Concurrence (PHEP awardees only)

   Awardees must provide documented evidence that at least a majority, if not all, of local health departments within their jurisdictions approves or concurs with the approaches and priorities described in the awardee funding applications. State applicants will be required to provide signed letters of concurrence upon request from local health departments or representative entities upon request. Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them.

8. Tribal Concurrence (PHEP awardees only)

   As applicable, awardees must provide documented evidence that a majority, if not all, of American Indian/Alaska Native tribes within their jurisdictions approves or concurs with the approaches and priorities described in the awardee funding applications. State applicants will be required to provide signed letters of concurrence upon request from tribal health departments or representative entities upon request. Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them.

Work Plan

The work plan describes awardees' planned activities for Budget Period 1. The work plan includes two components:

- Capabilities plan
- Subawardee contracts plan

Capabilities Plan

The capabilities plan component of the work plan is where awardees describe their planned activities for Budget Period 1 related to functions and resource elements outlined in ASPR'S *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning*..

HPP awardees must address all 8 healthcare preparedness capabilities, describing planned activities to achieve the 29 associated functions. To adequately address these capabilities, HPP awardees must address all required planning resource elements. Afterwards, awardees may choose to address other resource elements with planned activities based on priorities and needs, including all described within the HPP Requirements section of this funding opportunity announcement.

PHEP awardees must address all 15 public health preparedness capabilities, describing planned activities to achieve the 65 associated functions. PHEP awardees also must address resource elements associated with PHEP functions if there are planned activities

related to those resource elements for Budget Period 1. While awardee reporting on priority resource elements in Budget Period 1 is only required for those resource elements with planned activities, CDC expects that most of the priority resource elements will have planned activities if they are associated with a capability the awardee is addressing during Budget Period 1. Priority resource element activities should have measurable outputs linked to program objectives and outcomes.

Applications cannot be submitted if one or more functions are missing activity descriptions. A complete capabilities plan will include the following seven elements:

1. A chosen planned activity type for each function, using one of the following options:
    - Build
    - Sustain
    - Scale back
    - No planned activities this budget period

2. An indication and description of self-identified technical assistance needs if applicable for the function. Awardees are required to briefly describe that need for any identified functions.

3. A planned activities description that supports the chosen planned activity type for the function. Awardees should provide a brief narrative description of their activities, if any are planned for the budget period, and indicate whether the associated function is

implemented at the state level, local level, or a combination of the two. Narratives should include the identification of lead and supporting partners, a description of a projected timeline for completing the activities, and a description of how the planned activities will be implemented (e.g., meetings, exercises, surveys, inventories, plans, etc.).

4. If activities are planned for a function, awardees must provide a description of the funding types to be used to achieve a function, using one of the following funding types:
   - HPP (for HPP work plan)
   - PHEP (for PHEP work plan)
   - Other funding sources (must specify what other funds will be used)

   Note: Planned activities that are specifically funded by HPP or PHEP should be associated to a corresponding budget item.

5. Where ASPR- or CDC-defined performance measures are identified for a given function, awardees must provide a description of planned activities (e.g., drills, exercises, real incidents, routine activities) that will demonstrate the performance measure. Awardees should include a description of any tools and data collection systems or processes that will be used.

6. A chosen planned activity type for each resource element, using one of the following options:
    - Build
    - Sustain
    - Scale back
    - No planned activities this budget period

7. A planned activities description that supports the chosen planned activity type for the resource element. Awardees also should indicate whether the associated resource element is implemented at the state level, local level, or combination of the two and provide a brief description.

Subawardee Contracts Plan

Awardees who have subawardee contracts in their budgets may submit a subawardee contracts plan describing contractual arrangements with local or tribal health departments/entities, healthcare coalitions, or healthcare organizations. The plan should describe the full scope of work for subawardees within the awardee's jurisdiction and the specific capabilities addressed in the contract. For contracts that apply to multiple subawardees, each subawardee-specific contract line item in the budget should then reference the subawardee contract plan in the budget justification, rather than rewrite the required contractual elements multiple times.

Contracts not intended for multiple subawardees should be listed separately in the budget and not be included in the subawardee contract plan. For contracts to single entities, such as academic institutions or information management vendors, a subawardee contracts plan should not be submitted. For these individual contracts, all of the detailed contract information (found in the following Budget Section) should be included in the budget justification.

For each separate contract entered into the subawardee contracts plan, the following information must be submitted:

1. A unique contract name for the subawardee contract;
2. An indication of the type of subawardee or jurisdiction the plan is written for;
3. An indication of which capabilities or other work plan associations this contract will be supporting; and
4. A narrative that describes the scope of work and planned activities of the contract per capability. It is important to include this narrative for every capability included in the subawardee contracts plan.

Budget

Funding applications must meet the following budget requirements:

- Directly associate budget allocations with the appropriate work plan components to enable costs to be associated to capabilities or program administration activities.

- Provide a detailed line item budget (include SF-424A) and justification (including cost calculations) of the funding amount requested to support program activities for Budget Period 1.
- Submit budgets reflective of a 12-month budget period.
- Document maintenance of funding (MOF), which is defined as ensuring that awardee expenditures for public health security are maintained at a level not less than the average of such expenditures for the previous two years.
- Document projected sources of matching funds.
- All non-subawardee contracts, both newly requested and existing, must contain the following information requirements. If these contract elements are not available at application the contract budget line item could be restricted. Subawardee contract plan requirements are listed in the previous Subawardee Contracts Plan section.
    - Name(s) of contractor(s)
    - Scope of work
    - Method of selection (competitive or sole source); *procurement by noncompetitive proposals may be used only when the award of a contract is infeasible under small purchase procedures, sealed bids or competitive proposals and is justified under criteria in 45 Code of Federal Regulations Part 92.36.*
    - Period of performance
    - Method of accountability
    - Itemized budget with narrative justification

- *PHEP Awardees:* Funding local health departments to participate in NACCHO's Project Public Health Ready certification program is an allowable PHEP program cost.
- Awardees should consider the following in development of their budgets (SF-424A) and budget justification narratives.
  - The itemized budget for conducting the project and the corresponding justification is allowable under ASPR and CDC programs, is reasonable and consistent with public health and healthcare preparedness program capabilities, and consistent with stated objectives and planned program activities.
  - If awardees requests indirect costs in the budget, a copy of the current indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should have an effective date no more than 12 months prior to the application due date. The indirect cost rate agreement should be uploaded as a PDF file attachment when submitting via Grants.gov.
- Direct Assistance: Awardees planning to request direct assistance (DA) in lieu of financial assistance should complete and submit the DA request form no later than November 16, 2012. Note that DA may be requested for personnel (e.g., public health advisors, Career Epidemiology Field Officers, informatics specialists, or other technical consultants), provided the work is within scope of the cooperative agreements and is financially justified. DA also may be requested for any Statistical Analysis Software (SAS) licenses desired for future budget periods.

Additional budget preparation guidance is available at:

http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm; and

http://www.cdc.gov/od/pgo/funding/budgetguide.htm

Funding Restrictions

Restrictions, which apply to both awardees and their subrecipients, must be taken into account while writing the budget. Restrictions are as follows:

- Recipients may not use funds for fund raising activities or lobbying.
- Recipients may not use funds for research.
- Recipients may not use funds for construction or major renovations.
- Recipients may not use funds for clinical care.
- Recipients may not use funds to purchase vehicles.
- Recipients may not use funds for reimbursement of pre-award costs.
- Recipients may supplement but not supplant existing state or federal funds for activities described in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Payment or reimbursement of backfilling costs for staff is not allowed.
- None of the funds awarded to these programs may be used to pay the salary of an individual at a rate in excess of Executive Level II or $179,700 per year.

Guidance for Overlapping Budget Periods – PHEP only

Starting the new HPP-PHEP grant cycle July 1, 2012, and closing the current PHEP budget period on August 9, 2012, will result in a 39-day overlap of funding cycles. To avoid potential issues with, or the appearance of, inappropriate cost assignment by using both fiscal years 2011 and 2012 PHEP funds for the same services, PHEP awardees should exercise caution in calculation and submission of budgets and budget justifications.

In response to FOA TP12-1201, PHEP awardees are required to submit PHEP work plans and budgets that reflect their full funding allocations. Work plans and budget narratives should include specific PHEP project activities and budget justifications for spending fiscal year 2012 funds during the first 39 days of the aligned grant cycle that avoid double billing for items and services already charged to your currently funded FOA TP11-1101, Budget Period 11 (BP11), award. Awardees must ensure that funds budgeted for TP12-1201 for existing personnel (and contracts where applicable), do not duplicate costs or activities already funded during the overlapping period from July 1, 2012, through August 9, 2012, FOA TP11-1101.

For example:

- Costs for continuing personnel who were ***fully*** funded (100% full-time equivalent [FTE]) under the PHEP TP11-1101 for Budget Period 11, should be calculated at a level that ensures that the FTE charged does not exceed 100% FTE during the overlapping period of July 1, 2012, through August 9, 2012.

- Costs for continuing personnel *partially* funded under the PHEP TP11-1101, BP11, may be budgeted for a full 12 months as long as the total FTE charged does not exceed 100% during the overlapping period of July 1, 2012, through August 9, 2012.
- Contracts may be budgeted for a full 12 months as long as *any activities* and their resulting costs are not duplicated by those funded in the prior budget period during the overlapping period of July 1, 2012, through August 9, 2012.
- Other costs associated with new activities under TP12-1201 (BP1) may be funded for the full 12-month budget period, as long as they do not duplicate those costs or activities already funded under TP11-1101 during the overlapping period of July 1, 2012, through August 9, 2012.

Additional Submission Requirements

Electronic Submission

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC, Procurement and Grant Office, Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 E-mail:pgotim@cdc.gov Monday-Friday 7:30 a.m. - 4:30 p.m. for further instruction.

Note: Application submission is not concluded until successful completion of the validation process. After submission of your application package, applicants will receive a "submission receipt" email generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the funding opportunity announcement, applicants are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Nonvalidated applications will not be accepted after the published application deadline date.

In the event that you do not receive a "validation" e-mail within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0 page 57.

Applications must be submitted electronically at www.grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date. The application package can be downloaded from www.grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via

the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (http://www.grants.gov), are electronically time/date stamped and assigned a tracking number. The authorized organizational representative (AOR) will receive an e-mail notice of receipt when Grants.gov receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all Federal Holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the

Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to the GMO/GMS [See Section VII "Agency Contacts"], for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevented electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to the GMO/GMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

Intergovernmental Review

The application may be subject to Intergovernmental Review of Federal Programs as governed by Executive Order (EO) 12372. This order sets up a system for state and local governmental review of proposed federal assistance applications. While the HPP is not subject to this review, some PHEP programs may be affected. If so, under the new aligned HPP-PHEP FOA, the HPP component of the application for those jurisdictions would be submitted in the single application review process required for PHEP. Contact the state single point of contact (SPOC) as early as possible to alert the SPOC to

prospective applications and to receive instructions on the state's process. Visit the following Web address to get the current SPOC list: http://www.whitehouse.gov/omb/grants_spoc/.

Section V. Application Review Information

Criteria

Eligible applications must meet all requirements defined in this funding opportunity announcement. Specifically, eligible applications will be evaluated against the following criteria:

- Awardees' narrative descriptions for work plan activities, technical assistance needs, budget and five-year forecasts have a reasonable relationship, correlation, and continuity, where applicable, with data from past performance (e.g., public health and healthcare capabilities self-assessment data, prior year performance measures, and prior year application narratives and planned activities.
- Awardees have adequate planned activities to monitor and demonstrate ASPR and CDC defined performance measures and PAHPA benchmarks.
- Awardees have adequate planned activities to prioritize, build and sustain public health and healthcare capabilities during the budget period.
- Awardees have adequate planned activities which reflect progress to coordinate public health and healthcare preparedness program activities and leverage program funding streams

- The senior advisory committee or equivalent assists in the integration of preparedness efforts and strategic planning across the jurisdiction.
- Awardees' work plans (capabilities plans and subawardee contract plans) and budgets are clearly and adequately linked.
- Budget line items contain sufficiently detailed justifications and cost calculations.
- Documentation submitted or a description provided of the process used to engage local health departments and federally recognized American Indian/Alaska Native Tribes to reach consensus/approval/concurrence for the strategic approach or direction of the preparedness program. Examples of acceptable evidence include a copy of written consensus on official letterhead of a majority of local or tribal health officials whose jurisdictions encompass a majority of the state's population or a written recommendation of the SACCHO or Tribal Health Board or equivalent.
- Awardees have submitted exercise plans to the CDC/DSLR secure channel on LLIS.gov (http://www.llis.dhs.gov/)
- Completeness of the application.

Review and Selection Process

Applications will be initially reviewed for completeness by the CDC Procurement and Grants Office staff. In addition, applications will be jointly reviewed for responsiveness to the requirements contained in the funding opportunity announcement and technical acceptability by project officers from ASPR and CDC's Division of State and Local Readiness (DSLR) and subject matter experts (SMEs). Awardees will be notified of their awards, which will include the technical review report.

Section VI. Award Administration Information

Award Notices

Successful applicants will receive a notice of award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and ASPR and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the Principal Investigator named in the application. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Awards in response to this funding opportunity announcement will be subject to the DUNS, CCR Registration, and Transparency Act requirements.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- AR-1 Human Subjects Requirements
- AR-7 Executive Order 12372

- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2020
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-21 Small, Minority, and Women-Owned Business
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging while Driving, October 1, 2009

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

Reporting

- Pandemic influenza plans: Section 319C-1 of the PHS Act, as amended by PAHPA, currently requires that HPP and PHEP awardees annually submit influenza pandemic

plans. ASPR and CDC will provide further information on the 2012 submission in a separate guidance document. Section 319C-1 also requires withholding of funding from HPP and PHEP awardees that fail to submit acceptable pandemic influenza operations plans each fiscal year.

- Awardees must document and submit annually data on their current preparedness status and self-identified gaps based on the public health and healthcare preparedness capabilities as they relate to overall jurisdictional needs.

- Federal Funding Accountability And Transparency Act of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible Web site, www.USASpending.gov. The Web site includes information on each federal financial assistance award and contract over $25,000, including such information as:

    1. The name of the entity receiving the award;
    2. The amount of the award;
    3. Information on the award including transaction type, funding agency, etc.;
    4. The location of the entity receiving the award;
    5. A unique identifier of the entity receiving the award; and
    6. Names and compensation of highly compensated officers (as applicable).

Compliance with this law is primarily the responsibility of the federal agency. However, two elements of the law require information to be collected and reported by recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry; and 2) similar information on all sub-wards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following Web site: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf

- Updated Federal Financial Report cash transaction reports (FFR SF-425) must be filed in the Payment Management System (PMS) within 30 days of the end of each quarter (i.e., no later than October 30, 2012; January 30, 2013; and May 30, 2013). The FFR 425 form and instructions are available at:
    - http://www.whitehouse.gov/sites/default/files/omb/grants/standard_forms/ff_report.pdf
    - http://www.nea.gov/manageaward/FFR-Instructions.pdf

- Each funded awardee must provide an annual Interim Progress Report submitted via www.grants.gov: The interim progress report is due no less than 90 days before the end

of the budget period. The Interim Progress Report will serve as the noncompeting continuation application.

- Additionally, funded awardees must provide an original plus two hard copies of the following reports:
  - A mid-year progress report due 30 days after the first six months of the budget period. This report should include status updates on PAHPA benchmarks, applicable performance measure activities, and technical assistance plans; updates on current preparedness status and self-identified gaps based on the public health and healthcare preparedness capabilities as they relate to overall jurisdictional needs; and interim HPP and PHEP financial reports.
  - An annual progress report due 90 days after the end of the budget period. This report should include updates on work plan activities including local contracts, progress on implementation of technical assistance plans; budget expenditure reports; updates on PAHPA benchmarks and performance measurement activities; NIMS compliance activities, gap-based training, ESAR-VHP, and exercise reporting requirements (HPP only); and preparedness accomplishments, success stories, and program impact statements.
  - Separate HPP and PHEP Federal Financial Reports (FFR) SF-425) no later than 90 days after the end of the budget period.
  - Final performance and federal financial reports no later than 90 days after the end of the project period.
  - CDC and ASPR may require quarterly financial updates due 10 days after the end of each calendar quarter to monitor obligation of HPP and PHEP funds.

Audit Requirements

HPP and PHEP awardees are required to comply with audit requirements from the Office of Management and Budget (OMB) Circular A-133. Awardees that expend $500,000 or more in federal funds per year are required to complete an audit under this requirement. Information on the scope, frequency, and other aspects of the audits can be found at http://www.whitehouse.gov/omb/circulars.

In addition, HPP and PHEP awardees shall, not less often than once every two years, audit their expenditures from amounts received under these awards. Such audits shall be conducted by an entity independent of the agency administering a program funded, in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and using generally accepted auditing standards. Within 30 days following the completion of each audit report, the entity shall submit a copy of that audit report to the following office:

Federal Audit Clearinghouse, Bureau of the Census, 1201 E. 10th Street, Jeffersonville, Ind., 47132. Reporting packages for fiscal years 2008 and later must be submitted electronically online at the following Web site: http://harvester.census.gov/fac/collect/ddeindex.html.

Audits that indicate funds have not been spent in accordance with section 319C-1 or 319C-2 of the PHS Act may result in a disallowance decision requiring repayment or future withholding or offset of awards.

Awardees that satisfy OMB Circular A-133 audit requirements will also satisfy HPP and PHEP audit requirements.

Section VII. Agency Contacts

ASPR and CDC encourage inquiries concerning this announcement.

For HPP assistance, contact:

Mr. Robert Dugas

Chief, Hospital Preparedness Program Branch

U.S. Department of Health and Human Services (HHS)

Office of the Assistant Secretary for Preparedness and Response (ASPR)

Office of Preparedness and Emergency Operations (OPEO)

395 E ST., SW, 10th Floor, Suite 1075

Washington, D.C. 20201

Telephone: (202) 245-0732

Robert.Dugas@hhs.gov

For HPP Data and Evaluation assistance, contact:

Ms. Margaret Sparr

Chief, Healthcare Systems Evaluation Branch

U.S. Department of Health and Human Services (HHS)

Office of the Assistant Secretary for Preparedness and Response (ASPR)

Office of Preparedness and Emergency Operations (OPEO)

395 E ST., SW, 10th Floor, Suite 1075

Washington, D.C. 20201

Telephone: (202) 245-0771

Margaret.Sparr@hhs.gov

For ESAR-VHP assistance, contact:

Ms. Jennifer Hannah

Chief, Emergency System for Advance Registration

of Volunteer Health Professionals (ESAR-VHP)

U.S. Department of Health and Human Services (HHS)

Office of the Assistant Secretary for Preparedness and Response (ASPR)

Office of Preparedness and Emergency Operations (OPEO)

395 E ST., SW, 10th Floor, Suite 1075

Washington, D.C. 20201

Telephone: (202) 245-0722

Jennifer.Hannah@hhs.gov

For PHEP assistance, contact:

Ms. Sharon Sharpe,

Associate Director

Grants Management and Compliance, Division of State and Local Readiness

Department of Health and Human Services

Centers for Disease Control and Prevention

1600 Clifton Road, Mailstop D29

Atlanta, GA 30333

Telephone: (404) 639-0817

SSharpe@cdc.gov

For financial, grants management, or budget assistance, contact:

Ms. Glynnis Taylor, Grants Management Officer

Department of Health and Human Services,

CDC Procurement and Grants Office,

2920 Brandywine Road, Mailstop K69

Atlanta, GA 30341

Telephone: (770) 488-2752

gld1@cdc.gov

For assistance with submission difficulties, contact:

Grants.gov Contact Center

Telephone: 1-800-518-4726 E-mail: support@grants.gov

Hours of Operation: 24 hours a day, 7 days a week; closed on federal holidays.

For submission questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:

TTY 1-888-232-6348

Section VIII. Other Information

Additional information on reporting requirements is available at http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other ASPR and CDC funding opportunity announcements can be found at www.grants.gov.

Appendix 1
Hospital Preparedness Program (HPP)
Budget Period 1 (Fiscal Year 2012) Funding

Awardee	FY 2012 Total Funding Available
Alabama	$5,422,089
Alaska	$1,231,384
American Samoa	$318,412
Arizona	$7,082,390
Arkansas	$3,502,762
California	$28,752,455
Chicago	$3,275,881
Colorado	$5,678,980
Connecticut	$4,180,544
Delaware	$1,424,677
District of Columbia	$1,119,644
Florida	$19,861,267
Georgia	$10,476,179
Guam	$436,253
Hawaii	$1,900,815
Idaho	$2,114,269
Illinois	$10,936,885
Indiana	$7,176,908
Iowa	$3,637,084
Kansas	$3,438,092
Kentucky	$4,968,606
Los Angeles	$10,611,031
Louisiana	$5,168,389
Maine	$1,867,923
Marshall Islands	$317,821
Maryland	$6,445,505
Massachusetts	$7,242,636
Michigan	$10,678,003
Micronesia	$360,346
Minnesota	$5,961,891
Mississippi	$3,555,672
Missouri	$6,667,295
Montana	$1,518,883
Nebraska	$2,380,735
Nevada	$3,280,981
New Hampshire	$1,855,678
New Jersey	$9,553,742
New Mexico	$2,620,507
New York	$12,036,626
New York City	$8,918,612

Awardee	FY 2012 Total Funding Available
North Carolina	$10,319,477
North Dakota	$1,192,623
Northern Mariana Islands	$299,756
Ohio	$12,380,094
Oklahoma	$4,363,077
Oregon	$4,445,174
Palau	$271,501
Pennsylvania	$13,580,693
Puerto Rico	$4,336,754
Rhode Island	$1,583,915
South Carolina	$5,263,121
South Dakota	$1,338,429
Tennessee	$7,035,110
Texas	$26,394,469
Utah	$3,346,201
Vermont	$1,144,377
Virgin Islands (US)	$363,019
Virginia	$8,739,318
Washington	$7,424,816
West Virginia	$2,408,182
Wisconsin	$6,356,361
Wyoming	$1,080,412
TOTAL FY 2012 HPP FUNDING	**$351,644,731**

Appendix 2
Public Health Emergency Preparedness (PHEP)
Budget Period 1 (Fiscal Year 2012) Funding

Awardee	FY 2012 Total Base plus Population Funding	FY 2012 Cities Readiness Initiative Funding	FY 2012 Level 1 Chemical Laboratory Funding	FY 2012 Total Funding Available
Alabama	$8,779,918	$323,292	$0	$9,103,210
Alaska	$4,028,371	$169,600	$0	$4,197,971
American Samoa	$380,333	$0	$0	$380,333
Arizona	$10,729,577	$1,201,659	$0	$11,931,236
Arkansas	$6,526,088	$215,135	$0	$6,741,223
California	$36,176,330	$5,612,174	$1,051,433	$42,839,937
Chicago	$8,269,316	$1,577,831	$0	$9,847,147
Colorado	$9,081,579	$728,948	$0	$9,810,527
Connecticut	$7,321,994	$594,643	$0	$7,916,637
Delaware	$4,085,831	$323,925	$0	$4,409,756
District of Columbia	$5,727,636	$609,113	$0	$6,336,749
Florida	$25,735,574	$3,004,167	$808,167	$29,547,908
Georgia	$14,714,841	$1,510,027	$0	$16,224,868
Guam	$518,712	$0	$0	$518,712
Hawaii	$4,644,951	$273,184	$0	$4,918,135
Idaho	$4,895,606	$176,703	$0	$5,072,309
Illinois	$15,255,839	$2,059,598	$0	$17,315,437
Indiana	$10,840,569	$801,321	$0	$11,641,890
Iowa	$6,683,819	$204,893	$0	$6,888,712
Kansas	$6,450,147	$421,124	$0	$6,871,271
Kentucky	$8,247,400	$417,457	$0	$8,664,857
Los Angeles	$16,908,351	$3,151,142	$0	$20,059,493
Louisiana	$8,482,002	$564,662	$0	$9,046,664
Maine	$4,606,327	$169,600	$0	$4,775,927
Marshall Islands	$379,640	$0	$0	$379,640
Maryland	$9,981,696	$1,466,065	$0	$11,447,761
Massachusetts	$10,917,752	$1,341,928	$955,994	$13,215,674
Michigan	$14,951,839	$1,231,282	$939,437	$17,122,558
Micronesia	$429,576	$0	$0	$429,576
Minnesota	$9,413,797	$920,962	$968,730	$11,303,489
Mississippi	$6,588,218	$237,827	$0	$6,826,045
Missouri	$10,242,139	$947,176	$0	$11,189,315
Montana	$4,196,455	$169,600	$0	$4,366,055
Nebraska	$5,208,512	$212,712	$0	$5,421,224
Nevada	$6,265,654	$559,223	$0	$6,824,877
New Hampshire	$4,591,948	$289,501	$0	$4,881,449
New Jersey	$13,631,640	$2,401,592	$0	$16,033,232
New Mexico	$5,490,072	$254,231	$972,226	$6,716,529

Awardee	FY 2012 Total Base plus Population Funding	FY 2012 Cities Readiness Initiative Funding	FY 2012 Level 1 Chemical Laboratory Funding	FY 2012 Total Funding Available
New York	$16,547,244	$1,776,777	$1,602,584	$19,926,605
New York City	$14,915,090	$3,742,763	$0	$18,657,853
North Carolina	$14,530,829	$445,801	$0	$14,976,630
North Dakota	$4,028,371	$169,600	$0	$4,197,971
Northern Mariana Islands	$358,428	$0	$0	$358,428
Ohio	$16,950,573	$1,587,500	$0	$18,538,073
Oklahoma	$7,536,339	$359,099	$0	$7,895,438
Oregon	$7,632,745	$512,884	$0	$8,145,629
Palau	$325,248	$0	$0	$325,248
Pennsylvania	$18,360,413	$1,840,696	$0	$20,201,109
Puerto Rico	$7,505,428	$0	$0	$7,505,428
Rhode Island	$4,272,822	$301,660	$0	$4,574,482
South Carolina	$8,593,244	$284,781	$886,849	$9,764,874
South Dakota	$4,028,371	$169,600	$0	$4,197,971
Tennessee	$10,674,058	$750,039	$0	$11,424,097
Texas	$33,407,390	$4,144,467	$0	$37,551,857
Utah	$6,342,241	$322,189	$0	$6,664,430
Vermont	$4,028,371	$169,600	$0	$4,197,971
Virgin Islands (US)	$432,716	$0	$0	$432,716
Virginia	$12,675,277	$1,584,715	$838,795	$15,098,787
Washington	$11,131,682	$1,110,909	$0	$12,242,591
West Virginia	$5,240,742	$184,932	$0	$5,425,674
Wisconsin	$9,877,015	$529,540	$1,321,085	$11,727,640
Wyoming	$4,028,371	$169,600	$0	$4,197,971
TOTAL FY 2012 PHEP FUNDING	**$554,803,057**	**$54,299,449**	**$10,345,300**	**$619,447,806**

Appendix 3
Cities Readiness Initiative (CRI)
Budget Period 1 (Fiscal Year 2012) Funding

Awardee	CRI City	2010 Census Population	FY 2012 Awardee Total
Alabama	Birmingham	1,128,047	323,292
Alaska	Anchorage	380,821	169,600
Arizona	Phoenix	4,192,887	1,201,659
Arkansas	Little Rock	699,757	
Arkansas	Memphis	50,902	215,135
California	Los Angeles	3,010,232	
California	Riverside	4,224,851	
California	Sacramento	2,149,127	
California	San Diego	3,095,313	
California	San Francisco	4,335,391	
California	San Jose	1,836,911	
California	Fresno	930,450	5,612,174
Chicago	Chicago	2,695,598	1,577,831
Colorado	Denver	2,543,482	728,948
Connecticut	Hartford	1,212,381	
Connecticut	New Haven	862,477	594,643
Delaware	Philadelphia	538,479	
Delaware	Dover	162,310	323,925
Florida	Miami	5,564,635	
Florida	Orlando	2,134,411	
Florida	Tampa	2,783,243	3,004,167
Georgia	Atlanta	5,268,860	1,510,027
Hawaii	Honolulu	953,207	273,184
Idaho	Boise	616,561	176,703
Illinois	Chicago	5,891,011	
Illinois	St Louis	703,664	
Illinois	Peoria	379,186	2,059,598
Indiana	Chicago	708,070	
Indiana	Indianapolis	1,756,241	
Indiana	Cincinnati	79,262	
Indiana	Louisville	252,436	801,321
Iowa	Des Moines	569,633	
Iowa	Omaha	123,145	204,893
Kansas	Wichita	623,061	421,124

Awardee	CRI City	2010 Census Population	FY 2012 Awardee Total
Kansas	Kansas City	846,346	
Kentucky	Louisville	1,031,130	417,457
Kentucky	Cincinnati	425,483	
Los Angeles	Los Angeles	9,818,605	3,151,142
Louisiana	Baton Rouge	802,484	564,662
Louisiana	New Orleans	1,167,764	
Maine	Portland	514,098	169,600
Maryland	Baltimore	2,710,489	1,466,065
Maryland	Washington D.C	2,303,870	
Maryland	Philadelphia	101,108	
Massachusetts	Boston	4,134,036	1,341,928
Massachusetts	Providence	548,285	
Michigan	Detroit	4,296,250	1,231,282
Minnesota	Fargo	58,999	920,962
Minnesota	Minneapolis	3,154,469	
Mississippi	Jackson	539,057	237,827
Mississippi	Memphis	238,060	
Missouri	St. Louis	2,115,946	947,176
Missouri	Kansas City	1,188,988	
Montana	Billings	158,050	169,600
Nebraska	Omaha	742,205	212,712
Nevada	Las Vegas	1,951,269	559,223
New Hampshire	Boston	418,366	289,501
New Hampshire	Manchester	400,721	
New Jersey	New York City	6,471,215	2,401,592
New Jersey	Philadelphia	1,316,762	
New Jersey	Trenton	366,513	
New Mexico	Albuquerque	887,077	254,231
New York	Albany	870,716	1,776,777
New York	Buffalo	1,135,509	
New York	New York City	4,193,392	
New York City	New York City	8,175,133	3,742,763
North Carolina	Charlotte	1,531,965	445,801
North Carolina	Virginia Beach	23,547	
North Dakota	Fargo	149,778	169,600
Ohio	Cincinnati	1,625,406	1,587,500
Ohio	Cleveland	2,077,240	
Ohio	Columbus	1,836,536	

Awardee	CRI City	2010 Census Population	FY 2012 Awardee Total
Oklahoma	Oklahoma City	1,252,987	359,099
Oregon	Portland	1,789,580	512,884
Pennsylvania	Philadelphia	4,008,994	1,840,696
Pennsylvania	Pittsburgh	2,356,285	
Pennsylvania	New York City	57,369	
Rhode Island	Providence	1,052,567	301,660
South Carolina	Columbia	767,598	284,781
South Carolina	Charlotte	226,073	
South Dakota	Sioux Falls	228,261	169,600
Tennessee	Nashville	1,589,934	750,039
Tennessee	Memphis	1,027,138	
Texas	Dallas	6,371,773	4,144,467
Texas	Houston	5,946,800	
Texas	San Antonio	2,142,508	
Utah	Salt Lake City	1,124,197	322,189
Vermont	Burlington	211,261	169,600
Virginia	Richmond	1,258,251	1,584,715
Virginia	Virginia Beach	1,648,136	
Virginia	Washington D.C	2,623,079	
Washington	Seattle	3,439,809	1,110,909
Washington	Portland	436,429	
Washington D.C	Washington D.C	601,723	609,113
West Virginia	Charleston	304,284	184,932
West Virginia	Washington D.C	53,498	
Wisconsin	Chicago	166,426	529,540
Wisconsin	Milwaukee	1,555,908	
Wisconsin	Minneapolis	125,364	
Wyoming	Cheyenne	91,738	169,600
Total FY 2012 Cities Readiness Initiative Funding		**175,240,879**	**$54,299,449**

Appendix 4
At-a-Glance Summary of Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness

The *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* will assist state, local, Healthcare Coalition, and Emergency Support Function (ESF) #8 planners to identify gaps in preparedness, determine priorities, and develop plans for building and sustaining healthcare-specific capabilities. These capabilities are designed to facilitate and guide joint ESF #8 preparedness planning and ultimately assure safer, more resilient, and better-prepared communities. ASPR has identified the following eight capabilities (shown with their numeric designations that align with CDC's public health preparedness capabilities) as the basis for healthcare system, Healthcare Coalition, and healthcare organization preparedness:

1. Healthcare System Preparedness
2. Healthcare System Recovery
3. Emergency Operations Coordination
5. Fatality Management
6. Information Sharing
10. Medical Surge
14. Responder Safety and Health
15. Volunteer Management

How Capabilities Are Organized

The healthcare preparedness capabilities are numbered and presented to align with the public health emergency capabilities. Each of the eight capabilities includes a definition of the capability and the associated functions, performance measures, tasks, and resource considerations.

The **Capability** is defined as it applies to healthcare organizations, healthcare systems, and Healthcare Coalitions.

The **Functions** describe the critical elements that need to occur to achieve the capability.

The **Tasks** describe the steps that need to occur to complete the functions.

The **Resource Elements** section lists the resources that may be needed to successfully perform a function and the associated tasks. The resources are categorized into three elements:

- Plans or Planning: Elements that should be included in existing operational plans, standard operating procedures, and/or emergency operations plans
- Skills and Training: The competencies and skills that may be necessary for personnel and teams to possess to competently deliver a capability
- Equipment and Technology: The equipment that may be needed to achieve the capability

**Note: Certain resource elements have been identified as required. All resource elements may not be required to fully achieve the functions within a capability, but the awardee*

must address all required resource elements. Remaining resource elements are based on the priorities and needs of the identified target areas.

Capabilities and Corresponding Disaster Phases

Each of the healthcare preparedness capabilities aligns with a specific phase of the disaster cycle including preparedness, response, recovery, and mitigation. Capability 1, Healthcare System Preparedness, is the basis for all other healthcare capabilities and is designed to assist awardees in establishing and maintaining a capacity to develop, update, and test preparedness plans. In addition, each healthcare capability contains both preparedness and performance tasks and measures that support the capability outcome and serve as a guide for preparedness planning. These phases and the associated capability are shown in the following table:

Preparedness	Response	Recovery	Mitigation
Healthcare System Preparedness	Emergency Operations Coordination	Healthcare System Recovery	Healthcare System Preparedness
All other capabilities	Fatality Management		All other capabilities
	Information Sharing		
	Medical Surge		
	Responder Safety and Health		
	Volunteer Management		

Healthcare Preparedness Capabilities Planning Model

The healthcare preparedness capabilities are based on common preparedness methodologies from the U.S. Department of Homeland Security's Federal Emergency Management Agency (FEMA) regarding whole-of-community planning and in accordance with Presidential Policy Directive (PPD) 8: National Preparedness (March 30, 2011)[3]. This methodology is outlined in FEMA's *Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0*[4]. To assist awardees in using these new capabilities for local capability-based planning, the Office of the Assistant Secretary for Preparedness and Response (ASPR) suggests using the following planning model to develop strategies, objectives, and long-term goals to successfully address healthcare preparedness.

Planning Process[5]

The healthcare preparedness capabilities planning model mirrors the planning process of the U.S. Department of Homeland Security preparedness cycle and is outlined in Chapter

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[3] Presidential Policy Directive (PPD) 8: http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm.

[4] Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0, November 2010 (CPG 101, V.2): http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf.

[5] Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0, November 2010 (CPG 101, V.2), Chapter 4: http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf

4 of FEMA's *Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0*. This process is not intended to be a prescriptive methodology, but rather it is intended to describe a series of suggested activities for preparedness planning. Coordination with emergency management and ESF #8 planners during the following planning steps is imperative to ensure that healthcare organization priorities and needs are addressed in jurisdictional plans. The healthcare preparedness capabilities provide guidance on how this integration should occur. This FOA requires that the capability planning resource elements are to be addressed. To develop the required work plans and capability plans during strategic planning for the administration of the cooperative agreement, awardees are encouraged to follow a planning process that is similar to the capability-based planning model found in the healthcare preparedness capabilities. This model includes the following recommended steps:

Step 1: Form a Collaborative Planning Team
Capability 1: Healthcare System Preparedness; Function 1: Healthcare Coalition Development focuses on collaboration during preparedness. The awardee should collaborate with the appropriate emergency preparedness and response partners to develop priorities, goals, and objectives. This should include:

- Identifying Core Planning Partners: The awardee uses the concepts of collaborative planning to determine where to focus capabilities-based planning (Refer to Capability 1, Function 1)
- Engaging the Whole Community in Planning: The awardee engages the appropriate partners during capabilities-based planning to ensure the appropriate community stakeholders have been engaged (Refer to Capability 1, Function 1)

Step 2: Understand the Situation
This is vital in the development of the programs goals and objectives related to capability development. During the five year project period, the awardee must be able to identify the reasoning behind program initiatives. These justifications should be based on the priorities and needs at the local healthcare and jurisdictional level. Therefore, basing program initiatives on risks and hazards is an approach that needs to be considered. This should include:

- Identifying Threats and Hazards: The awardee identifies capability-based planning needs based on the ongoing processes for hazard vulnerability assessments
- Assessing Risk: The awardee identifies capability-based planning needs based on the ongoing processes for risk assessments in order to ensure healthcare priorities and needs are addressed

Step 3: Determine Goals and Objectives
In Capability 1: Healthcare System Preparedness, Functions 2 and 3; healthcare priority objectives and needs are explained for local healthcare and jurisdictional levels. The awardee should mirror this process to determine the program goals and objectives. This includes:

- Determining Priorities: Based on risks and needs of local healthcare, the awardee identifies healthcare priorities for capabilities-based planning that are required to ensure healthcare system preparedness. This should be done during one-year budget periods and the five-year project period to help determine the short- and long-term objectives.
- Setting Goals and Objectives: Based on the identified priorities, the awardee identifies healthcare goals and objectives for capabilities-based planning that are required to ensure healthcare system preparedness. Objectives should be developed for one-year budget periods and the five-year project period.
- Determining Strategic Outcomes: The awardee outlines long-term outcomes based on the priority goals and objectives that will ensure the healthcare preparedness capabilities are addressed per cooperative agreement requirements.

Step 4: Plan Development
In Capability 1: Healthcare System Preparedness, Functions 2; plan development is explained for local healthcare and jurisdictional levels. The awardee should mirror this process to develop budget period and project period program plans. This should include:

- Identifying Resources: The awardee should determine the response and recovery needs of local healthcare that are required to successfully achieve the strategic outcomes through processes such as gap analysis and needs assessments. The identification of these needs or gaps should drive the development of program preparedness activities. This process should be done yearly and should incorporate findings from evaluative processes to assist the advancement of preparedness.
- Developing and Analyzing Courses of Action: Based on the resource needs and the prioritized goals and objectives, the awardee should develop budget period and project period courses of action necessary to achieve capabilities-based planning objectives. These operational concepts should be developed for each budget period and for the five year project period.

Step 5: Plan Preparation, Review, and Approval
During development of program planning for the budget period, the awardee should work with the project officer for assistance to ensure local and jurisdictional preparedness outcomes are met. This should include the writing, reviewing, and approval of the plan.

Step 6: Plan Implementation and Maintenance
Throughout the implementation of the work plan, the awardees are expected to meet the requirements of the FOA regarding training, exercising and evaluation. These can be found in the HPP-specific requirement sections of this document. Capability 1: Healthcare System Preparedness also provides guidance in these areas in the planning resource elements. Implementation and maintenance should include:

- Training: The awardee develops training plans that provide the knowledge, skills, and abilities that support capability-based preparedness activity inclusive of healthcare organizations needs and priorities.

- Exercising: The awardee develops and exercise program that tests capability-based plans inclusive of healthcare organizations. This is dependent on the needs and priorities of the healthcare organizations.
- Evaluating, revising, and maintaining: The awardee develops evaluative processes to review, revise, and maintain capabilities-based plans. This is based on the resulting priorities, needs, findings, and corrective actions of exercises, real incidents, training, or needs assessments of the healthcare organizations. Evaluative processes are ongoing and assist planners to assess preparedness status and address gaps during the continuous preparedness cycle. This includes review of standing risk assessments and hazard vulnerability assessments to update plans with new findings. It also includes strategic assessments of the program and the capabilities-based approach to determine if the strategies have been successful. Ongoing resource needs assessments of targeted stakeholders will help determine priorities for the next cycle. Finally, the evaluation of exercises and training is vital to inform the evaluation corrective action process. All of these are steps in preparedness continuous quality improvement and are essential during capabilities-based preparedness efforts.

To assist with the planning process, we have provided a summary that includes the capability definitions, functions, required and priority-based resource elements, and associated performance measures. The complete document, *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*, is available at: http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.

Healthcare Preparedness Capabilities – Summary of Required Resources and Performance Measures

Capability 1: Healthcare System Preparedness

Definition: Healthcare system preparedness is the ability of a community's healthcare system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, community and faith-based partners, state, local, and territorial governments to do the following:

- **Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community**
- **Provide timely monitoring and management of resources**
- **Coordinate the allocation of emergency medical care resources**
- **Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders**

Healthcare system preparedness is achieved through a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.

Associated Performance Measures:

- HPP Specific Measure **#1: Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness***
    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Develop, refine, or sustain Healthcare Coalitions

Required Resource Elements:

P1: (*Required*) Healthcare Coalition regional boundaries:

The State and Healthcare Coalition member organizations identify the geographic boundaries of the Healthcare Coalition. Healthcare Coalitions are developed around or within a functional service region/area based on unique needs of that region/area. The participation of the Healthcare Coalition is evidenced by written documents (e.g., charters, by laws or other supporting evidence based documents) that establish the Healthcare Coalition for the purpose of disaster preparedness. Examples of a region or area may include:

- Healthcare service catchment area
- Trauma region
- Emergency Medical Service (EMS) region
- Regional Coordinating Hospital region
- Public Health region/district
- County jurisdiction
- Emergency Management Agency (EMA) region
- Other type of functional service region

P2: (*Required*) Healthcare Coalition primary members:

Healthcare organization participation in emergency management preparedness and planning may include formation of Healthcare Coalitions as a component of a larger planning organization or region (e.g., EMS or EMA regions). This may also include supporting the healthcare organizations to form Healthcare Coalitions around healthcare delivery areas (e.g., Regional Coordinating Hospital Region, etc.) and obtaining input for preparedness from relevant response organizations and stakeholders. The State role in Healthcare Coalitions is to form a partnership with or to provide support for healthcare organizations in the effort for multi-agency coordination for preparedness and response.

P3: (*Required*) Healthcare Coalition essential partner memberships:

The State and Healthcare Coalition member organizations encourage the development of essential partner memberships from the community's healthcare organizations and response partners. These memberships are essential for ensuring the coordination of preparedness, response, and recovery activities. Memberships may be dependent on the area, participant availability, and relevance to the Healthcare Coalition. Prospective partners to engage (assuming they are not already members):

- Hospitals and other healthcare providers
- EMS providers
- Emergency Management/Public Safety
- Long-term care providers
- Mental/behavioral health providers

- Private entities associated with healthcare (e.g., Hospital associations)
- Specialty service providers (e.g., dialysis, pediatrics, woman's health, stand alone surgery, urgent care)
- Support service providers (e.g., laboratories, pharmacies, blood banks, poison control)
- Primary care providers
- Community Health Centers
- Public health
- Tribal Healthcare
- Federal entities (e.g., NDMS, VA hospitals, IHS facilities, Department of Defense facilities)

Note: Active membership from these constituencies are evidenced by written documents such as MOUs, MAAs, IAAs, letters of agreement, charters, or other supporting evidence documents

P4: (*Required*) Additional Healthcare Coalition partnerships/memberships:

The State and Healthcare Coalition member organizations network with subject matter experts (SMEs) for improved coordination of preparedness, response, and recovery activities. These memberships may be dependent on the area, participant availability, and the Healthcare Coalition's unique needs. Examples of organizations that may be considered include but are not limited to:

- Local and state law enforcement and fire services
- Public Works
- Private organizations
- Non-governmental organizations
- Non-profit organizations
- Volunteer Organizations Active in Disaster (VOAD)
- Faith-based Organizations (FBOs)
- Community-based Organizations (CBOs)
- Volunteer medical organizations (e.g., American Red Cross)
- Others partnerships as relevant

Note: Active membership is evidenced by written documents such as MOUs, MAAs, IAAs, letters of agreement, charters, or other supporting documents. Evidence based documents demonstrate membership from healthcare subject matter experts or other healthcare organizations from both the public and private sector

Note: Additional supporting evidence based documents may include correspondence such as emails or meeting minutes but should clearly demonstrate that SME input has been coordinated

P5: (*Required*) Healthcare Coalition organization and structure:

Healthcare Coalition members establish a collaborative oversight and coordination structure. At a minimum, the Healthcare Coalition oversight and structure should include:

- A Leadership structure determined and appointed by the Healthcare Coalition
- An advisory board-like function with multi-agency representation from members of the Healthcare Coalition
    - The advisory board should provide consultative and informed input into key decisions and ensure integrated planning similar to that of a multi-agency coordinating group
- A clear structure that can coordinate with the local and state emergency operations center
    - This includes a primary point of contact (POC) and/or a process that serves as the liaison/method to communicate with ESF#8 and Emergency Operations Centers (EOCs) during response
- Clearly defined roles and responsibilities for each participating member as it relates to disaster preparedness, response, and recovery
- Strategies to empower and sustain the Healthcare Coalition as an entity
    - Documents that outline the guidelines, participation rules, and roles and responsibilities of each agency in the Healthcare Coalition
    - Plans for the financial sustainability of the Healthcare Coalition in the absence of Federal funding
    - Processes to implement and document the administrative responsibilities needed to maintain the Healthcare Coalition

P6: (*Required*) Multi-agency coordination during response:

The State and the Healthcare Coalition, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders develop a plan to ensure healthcare organizations are represented in incident management decisions during an incident. Multi-agency coordination will vary depending on the location of the Healthcare Coalition. Options for this type of representation may include either a response role as a part of Multi-Agency Coordination System (MACS) or by providing plans for incident management to guide decisions regarding healthcare organization support. Whether the coordination is done through actual response or by planning, the coordination should guide the protocols for:

- Healthcare organization coordination with ESF #8
- Healthcare organization coordination with incident management at the Federal, state, local, tribal, and territorial government levels

- Information sharing procedures between healthcare organizations and incident management
- Resource support to healthcare organizations

Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster

Required Resource Elements:

P1: (*Required*) Healthcare system situational assessments:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, coordinate to develop a situational assessment of the local healthcare delivery areas that comprise the Healthcare Coalition regions. A coordinated healthcare situational assessment is adapted from the local hazard vulnerability assessments and risk assessments. The assessment includes a prioritization of threats to the community's ability to deliver healthcare during response. The assessment also includes estimates of casualties and fatalities based on the identified risks. The components of the situational assessment include:

Regional (planning area) characteristics such as:

- Demographics of the planning area including identification of at-risk individuals that may require special medical needs
- Specific characteristics regarding at-risk individuals and those with special medical needs (e.g., dialysis center locations and access, nursing home locations and access). For supporting information, please see Function 7 in this Capability
- Geographical characteristics that may impede healthcare delivery (e.g., flood plains, poor road conditions)

Coordination and integration of healthcare assessments with the appropriate local hazard vulnerability assessment (HVAs) and risk assessments should include:

- The following incident scenarios:
    - Local natural and human-caused hazards
    - Priority natural and human-caused catastrophic health incidents
    - Scenarios in which the community is cut off from outside support and/or the basic infrastructure is disrupted
- Integration with local HVA/risk assessment and include the needs of at-risk and vulnerable individuals
- Joint analysis and prioritization of the threats to the community using common healthcare planning assumptions from the State and healthcare organizations

- Identification and integration of the priority healthcare assets and essential services into the assessment (For supporting information, please see Function 3 in this Capability)
- Coordinate with ongoing public health risk assessment initiatives (For supporting information, please see PHEP Capability 1 — Community Preparedness)
- Estimates of the anticipated number of casualties that contribute to surge and fatality management planning (based on identified and prioritized risks).

Note: The situational assessment, which includes the risk assessment or HVA, casualty estimates, and the development of healthcare priorities, is used to determine future preparedness activities including planning, training, exercising and equipping

P2: (*Required*) Healthcare System disaster planning:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, collaborate to develop local and state all-hazards and ESF #8 plans. Plans should include, but are not limited to the following elements that:

- Include healthcare organizations objectives and priorities for response based on the HVA and risk assessment
- Assist healthcare organizations to perform capabilities required to prevent, protect against, respond to, and recover from all-hazards events when and where they are needed
- Coordinate vertically and horizontally with appropriate departments, agencies, and jurisdictions
- Provide a process to request local, state, and Federal assistance for healthcare organizations
- Provide the processes for requesting assistance from community partners and stakeholders and other healthcare organizations
- Coordinate healthcare organization operations with the local or state emergency operations center to assist with disaster response
- Define healthcare organization roles and responsibilities for response
- Coordinate the development of annexes that include specific healthcare delivery priorities including but not limited to:
    - Medical Surge Management
    - Information Management
    - Communications
    - Continuity of Operations
    - Fatality Management

Function 3: Identify and prioritize essential healthcare assets and services

Required Resource Elements:

P1: (*Required*) Identify and prioritize critical healthcare assets and essential services:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, perform community healthcare assessments to identify and prioritize healthcare assets and essential services that are vital for healthcare delivery. These assessments should identify the following critical services and key resources (not inclusive):

- Critical medical services (e.g., trauma, radiology, critical care, surgery, pediatrics, EMS, decontamination, isolation)
- Critical medical support services (e.g., patient transport services, pharmacy, blood banks, laboratory, medical gas suppliers)
- Critical facility management services (e.g., power, water, sanitation, generators, heating, ventilation, and air conditioning (HVAC), elevators)
- Critical healthcare information systems for information management/communications (e.g., failover and back up, remote site hosting)
- Key healthcare resources (e.g., staffing, equipment, beds, medical supply, pharmaceuticals)

P2: (*Required*) Priority healthcare assets and essential services planning:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain resource management processes to assist healthcare organizations with resources support. This support should assist healthcare organizations to maintain the priority healthcare assets and continue essential services during a response. Coordinated plans for resource assistance (e.g., space, staffing, equipment, supplies, services and systems) should include but is not limited to the following elements:

- Processes for healthcare organizations to quickly restore essential medical services in the aftermath of an incident
- Strategies for resource allocation that assist with the continued delivery of essential services during response
- Processes for healthcare organizations to request assistance and activate resource agreements to improve access to resources and emergency supply lines

    - The objective should be to extend operational ability well past the 96 hour standard (The Joint Commission EM.02.01.01 EP3) and if possible up to recovery
- Options for healthcare organizations to obtain assistance from a local or regional cache if available
- Processes to coordinate with healthcare organizations to assist with the movement of patients to alternate locations to receive critical medical treatment or evaluation (e.g., radiology, critical care)
- Processes to assist healthcare organizations with the decompression (clearing) of critical beds by assisting with the movement of patients to alternate facilities (For supporting information, please see Capability 10 — Medical Surge)
- Processes to assist healthcare organizations with the provision of special services/teams to support patient care and treatment (e.g., DMAT Teams, mobile radiology, mobile pharmacy, transportation, etc.)
- Processes to disseminate Federal-, state- and regional-based pharmaceutical caches and medical supplies

E1: (*Based on priorities and needs*) Equipment to assist healthcare organizations with the provision of critical services:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need for equipment that can be used to assist healthcare organizations with essential services in a disaster. This equipment may include but is not limited to:

- Equipment that can provide specialty medical services (e.g., mobile pharmacy)
- Equipment that can deliver power, HVAC, potable water, provide food storage, or other equipment that sustain essential patient services
- Systems that can provide redundant communication and information management capability (e.g., failover and back up, remote site hosting)
- Medical equipment, medical supply, and pharmaceuticals
- Equipment to secure caches of critical medical supplies and pharmaceuticals and provide necessary environmental storage devices to maintain the appropriate environment (climate control)

Function 4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps

Required Resources Elements:

P1: (*Required*) Healthcare resource assessment:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, perform a healthcare organization resource assessment in order to identify:

- Healthcare organization resource gaps for incident response including those in:
    - Communication
    - Transportation
    - Manpower (e.g., stabilize/maintain staff after an event)
    - Equipment and supplies
    - Surge or alternate care space
    - Specialty services
    - Other resources identified by the gap analysis/corrective actions
- Categorization of the available assets within the region that could be used to address resource gaps
- Available resource assistance from accessible public or private caches
- Mutual aid agreements for resources from public and private sector (if the healthcare organization is willing to participate)
- Local, state, and Federal resources available through the appropriate request process
- Deconfliction of over allocated resources (competing priorities for the same resource at the same time)

P2: (*Required*) Healthcare resource coordination:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain coordinated resource processes that assist healthcare organizations to effectively obtain resources during response and recovery. This should include processes to assist healthcare organizations to:

- Immediately request and obtain resources from available caches
- Retain viable options for resource allocation and sharing that involves the community, private sector, and other stakeholders
- Request resources from the local, state, and Federal level of emergency operations (e.g., NDMS)

P3: (*Required*) Address healthcare information gaps:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, and relevant response partners

and stakeholders, develop, refine, and sustain plans that address information gaps in order to:

- Ensure communication and data interoperability for healthcare and response partners
- Assist with information sharing between local and state partners during an incident or event

Function 5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond

Required Resource Elements:

P1: (*Required*) Healthcare organization - National Incident Management System (NIMS) training:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain healthcare strategies that assist healthcare organizations with NIMS training. This includes processes and strategies to:

- Promote NIMS adoption with healthcare organizations
- Support NIMS implementation with healthcare organizations
- Assist healthcare organizations to revise and update healthcare organization Emergency Operation Plans to incorporate NIMS and NRF components
- Assist healthcare organizations develop, refine, and sustain interagency mutual aid agreements, (e.g., agreements with public, private sector, and nongovernmental organizations)
- Assist healthcare organizations with FEMA 100, 200, and 700 level training or equivalent training
- Assist healthcare organizations with FEMA 800 level training or equivalent training
- Integrate NIMS concepts and principles into healthcare organization-related training and exercises
- Promote and encourage healthcare organization protocols, equipment, communication, and data interoperability to facilitate the collection and distribution of consistent and accurate information with state and local partners during an incident
- Promote the application of common and consistent terminology during response

- Ensure all emergency incidents, exercises, and preplanned (recurring/special) events are managed with a consistent application of ICS organizational structures, doctrine, processes, and procedures
- Assist healthcare organizations with adoption of the principle of Public Information, facilitated by the use of the Joint Information System (JIS) and Joint Information Center (JIC)

S1: (*Based on priorities and needs*) Training to address healthcare gaps and corrective actions:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, provide training to address identified healthcare response gaps and corrective actions. Training should be based on the specific needs (i.e., knowledge, skills, and abilities) identified by healthcare organizations

Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation

Required Resource Elements:

P1: (*Required*) Exercise plans:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain coordinated exercise plans to guide exercise implementation. Coordinated exercise plans should include but are not limited to the following elements:

- An exercise schedule
- An annual update plan
- An approach for testing healthcare system capabilities
- Roles and responsibilities of the participating healthcare entities

P2: (*Required*) Exercise implementation and coordination:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, should exercise capabilities based on identified gaps and subsequent corrective actions. Exercise implementation and coordination should include:

- Exercises based on the guidance and concepts of HSEEP or equivalent program
- The encouragement of healthcare organization participation to address gaps in capabilities

- Horizontal and vertical coordination with relevant response partners and stakeholders to include Federal, state and local response teams. (i.e., DMATs)

P3: (*Required*) Evaluation and improvement plans:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, implement evaluation methods to inform risk assessments, manage vulnerabilities, allocate resources, and guide the elements of preparedness. Evaluation methods should include but are not limited to:

- HSEEP, or equivalent, based capability assessment guidance
- The coordination of After Action Reports (AAR) for exercises/actual incidents
- The coordination of improvement plans for exercises/actual incidents
- The integration of findings from the improvement plan into the next planning, training, exercise, and resource allocation cycle

P4: (*Required*) Best practice and lessons learned sharing:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a means to share best practices and lessons learned.

S1: (*Required*) Exercise and evaluation training:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, provide exercise and evaluation training to assist healthcare organizations with the concepts of exercise coordination, implementation, and evaluation.

Function 7: Coordinate with planning for at-risk individuals and those with special medical needs

Required Resource Elements:

P1: (*Required*) Healthcare planning for at-risk individuals and functional needs:

The State and Healthcare Coalitions, in coordination with healthcare organizations, ESF #6, public health, emergency management, ESF #8, relevant response partners, and stakeholders, participate in planning to determine the appropriate protocols regarding individuals with functional needs so that assistance and guidance can be provided to healthcare organizations upon request.

P2: (*Required*) Special medical needs planning:

The State and Healthcare Coalitions, in coordination with healthcare organizations, engage with the appropriate agencies and participate in planning for individuals having special medical needs and whose care can only occur at healthcare facilities. Plans should include:

- Courses of action to ensure individuals will be seen by the appropriate healthcare personnel during an incident
- Coordination with EMS to improve transport capabilities
- Coordination with alternative transportation capable of supporting individuals with special medical needs
- Coordination with public health and ESF#6 mass care planning to determine the transfer and transport options and protocols for individuals with special medical needs to and from shelters/healthcare facilities

Capability 2: Healthcare System Recovery

Definition: Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community.

Associated Performance Measures:

- HPP Specific Measure #2: **Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations**
    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Develop recovery processes for the healthcare delivery system

Required Resource Elements:

P1: (*Required*) Healthcare recovery planning:

The State, in coordination with Healthcare Coalitions, healthcare organizations, emergency management, local, state, and Federal recovery coordinators, relevant response partners, and stakeholders, participate in the process to develop recovery plans that integrate healthcare recovery priorities. These plans should include but are not limited to the following elements:

- Assessment of the local healthcare system(s) to identify risks and vulnerabilities that may impede recovery (For supporting information, please see Capability 1 — Healthcare Preparedness)
- Identification of local, state and Federal disaster recovery coordinators that will provide recovery assistance
- A process to communicate needs with disaster recovery coordinators
- Identification of community and government partners for recovery support, resources, and systems
- Coordination with health licensing and regulation agencies for guidance with recovery processes
- Coordination with recovery partners and partner healthcare organizations to develop collaborative strategies for the continued delivery of essential healthcare services post-disaster (For supporting information, please see Capability 1 — Healthcare Preparedness)

P2: (*Required*) Assessment of healthcare delivery recovery needs post disaster:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, local, state, and Federal recovery coordinators, relevant response partners, and stakeholders, perform an assessment of healthcare organizations recovery needs post-disaster. This process should include but is not limited to the following elements:

- Coordination with healthcare organizations to identify immediate operating needs for the delivery of essential healthcare services
- Coordination with partner healthcare organizations to identify possible long-term healthcare recovery priorities
- Processes to communicate healthcare recovery priorities to the local and state agencies responsible for recovery

P3: (*Required*) Healthcare organization recovery assistance and participation:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, local, state, and Federal recovery coordinators, relevant response partners, and stakeholders, participate in the development of processes to provide assistance when available and requested by healthcare organizations to enable effective and rapid recovery support. This process may include but is not limited to the following elements:

- State promotion of the National Disaster Recovery Framework (NRDF) process
- Assistance to healthcare organizations to communicate recovery needs to the local, state or Federal disaster recovery coordinator
- Implementation of plans to assist healthcare organizations with the process to request and obtain resources (if available) and continue the delivery of essential services (For supporting information, please see Capability 3 — Emergency Operations Coordination)
    - The plan should encompass multiple sources of resource support until normal operations can be resumed. This should be based on the priorities of the healthcare system but may be unsupportable depending on the disaster impact (damage and cost)
- Provide guidance to healthcare organizations for the completion of the State and/or Federal processes for reimbursement, reconstitution, and resupply when requested. This does not imply a responsibility of reimbursement, reconstitution or resupply, but rather creates a process for it
- Development of risk mitigation strategies based on corrective actions

Note: An assistance process does not imply that the State or Healthcare Coalition is responsible for reconstitution of a healthcare organization. It only addresses assistance with the processes to recover.

Function 2: Assist healthcare organizations to implement Continuity of Operations (COOP)

Required Resource Elements:

P1: (*Required*) COOP planning assistance for healthcare organizations:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders participate with the development of coordinated plans to assist healthcare organizations with COOP plan development and COOP operations. These plans may include but are not limited to the following elements:

- Coordination with healthcare organizations to assess COOP capabilities
- Guidance to healthcare organizations for COOP planning
- Coordination of healthcare COOP plans with local and state emergency operation and ESF #8 plans
- Assistance to healthcare organizations for the development of COOP sites if requested
- Processes to request and obtain resources during COOP

- Communication protocols for healthcare organizations to communicate with the relevant response partners and stakeholders during COOP

P2: (*Required*) Healthcare organization COOP implementation assistance:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain processes to assist with the implementation of coordinated COOP strategies that assist activation, relocation and continuity of operations for healthcare organizations. These processes should include but are not limited to the following elements:

- Alert and notification procedures for COOP activation
- Monitoring COOP operations
- Processes to provide assistance to healthcare organizations during COOP operations when requested and available
- A means to recognize and understand healthcare organizations shelter-in-place operations and alternate care site operations plans including (assumes healthcare organization cooperation to share plans):
    - Orders of successions and delegations of authorities
    - Location of continuity facilities
    - Continuity communications plan
    - Continuity staffing plan (Human capital)
    - Reduced/altered operations for in-facility movement of service (devolution plan)
    - Plan for management of vital services
- Coordinated strategies for assisting healthcare organization during devolution operations if any can be provided

P3: (*Required*) Healthcare organization recovery assistance:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, respective recovery coordinators, relevant response partners, and stakeholders, participate with the development of a plan to assist with recovery and reconstitution of healthcare essential services to the impacted region. COOP recovery plans should include but are not limited to the following elements:

- Identification of healthcare organizations healthcare recovery needs to move from COOP to normal operations
- Assistance to healthcare organizations for the return from continuity operations to normal operations if requested and available

- Guidance to assist healthcare organizations with the process for reimbursement, reconstitution, or resupply for the transition from COOP to normal operations

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the public have relevant and timely information about the status and needs of the healthcare delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community response and according to the framework of the National Incident Management System (NIMS).

Associated Performance Measures:

- HPP Specific Measure #3: **Percent of healthcare coalitions (HCCs) that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters**
    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Healthcare organization multi-agency representation and coordination with emergency operations

Required Resource Elements:

P1: (*Required*) Healthcare organization multi-agency coordination during response:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to determine how multi-agency coordination and representation for healthcare organizations should be activated

and integrated into local and state emergency operations during an incident response. This plan should include, but is not limited to the following elements:

- Processes to determine healthcare organization representation in the local and state Emergency Operations Centers (EOCs). This may include:
    - Representation of the Healthcare Coalition on behalf of the healthcare organizations that integrates with Multi-Agency Coordination Systems (MACS) at the local and state EOCs upon request
    - Other methods of representation as decided by the individual healthcare organizations
- Identification of resource needs that require multi-agency coordination and representation of healthcare organizations
- Processes to request and activate multi-agency coordination

P2: (*Required*) Healthcare organization and emergency operations decision coordination:

The State and Healthcare Coalition, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, determine how decisions regarding healthcare organization information and resource management are coordinated and integrated into emergency operations. This coordination is initiated by either multi-agency representation of healthcare organizations at the EOC or by plans and protocols that assist incident management with an incident response.

Function 2: Assess and notify stakeholders of healthcare delivery status

Required Resource Elements:

P1: (*Required*) Healthcare organization resource needs assessment:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a coordinated plan that can be used by emergency operations to quickly assess the status and needs of healthcare organizations within the community during an incident response. This plan should include, but is not limited to the following elements:

- Protocols to ensure appropriate multi-agency coordination for emergency response and recovery operations
- Protocols to communicate the operational status of healthcare organizations
- Protocols to communicate the resource needs of affected healthcare organizations at the outset of any emergency

For supporting information, please see Capability 6 — Information Sharing

P2: (*Required*) Incident information sharing:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, response partners, and stakeholders, develop, refine, and sustain a plan to provide healthcare organizations with relevant and timely incident information. The plan may include but is not limited to processes to communicate:

- The status of the incident
- The status of operations of partner healthcare organizations
- Availability of resources to perform response operations
- The level of healthcare organization activation that may be required to respond

P3: (*Required*) Community notification of healthcare delivery status:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan for communication that provides a unified message about the status of healthcare delivery through a Joint Information System (JIS) for dissemination to the community.

Note: This does not override a healthcare organizations ability to provide messages to the community but encourages "one voice" during public messaging as advocated by NIMS

Function 3: Support healthcare response efforts through coordination of resources

Required Resource Elements:

P1: (*Required*) Identify available healthcare resources:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, determine resource availability to address resource gaps during response. This should include but is not limited to the following elements:

- Identification of available resources from accessible public or private caches
- Identification of mutual aid processes for resources from the public and private sector (assuming healthcare organizations would participate)
- Identification of local, state, and Federal resources through the appropriate request process

- Deconfliction of over allocated resources (competing priorities for the same resource at the same time)
- Identification of assets that the Healthcare Coalition has the authority to allocate
- Identification of regional mobile medical assets and caches of medical equipment and supplies
- Identification of processes to utilize the State's volunteer management system to identify trained, credentialed staff to assist with patient care or other duties during surge operations (Capability 15 — Volunteer Management)
- Identification of other regional resource management processes (redundant sources of supply)

For supporting information, please see Capability 1 — Healthcare Preparedness

P2: (*Required*) Resource management implementation:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, implement processes for resource management that include but are not limited to the following elements:

- Coordinate assistance for resources from locally available caches when requested and available
- Assist healthcare organizations with implementation of mutual aid processes upon request
- Allocate locally controlled assets through the Healthcare Coalition (if authorized)
- Assist local, state, and Federal incident management with coordination of resource requests from healthcare organizations
- Utilize alternate sources of resources (e.g., emergency supply chains and private vendor support for critical resources such as equipment, supplies, space or other resource) if requested and available

P3: (*Required*) Public health resource support to healthcare organizations:

The State and Healthcare Coalition, in coordination with healthcare organizations, public health emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to coordinate with the State and local health departments in order to request support services, guidance and/or resources for public health related requirements. This should include but is not limited to the following elements:

- Surveillance services (e.g., daily monitoring and coordination with public health during incidents requiring bio-surveillance)
- Epidemiological investigation

- Public health laboratory services
- Guidance on prevention measures for injury, infectious disease, and other major health threats during an incident
- Alternate care sites
- Other requirements that necessitate support from the local and state health departments

P4: (*Required*) Managing and resupplying resource caches:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a coordinated plan that assists healthcare organizations by managing and resupplying caches. This should include but is not limited to the following elements:

- Processes to track, record, and effectively inventory available resources for healthcare organization use during emergency operations
- Coordination with the appropriate agencies for the resupply of specific caches (e.g., Strategic National Stockpile)
- Processes for the rapid resupply of depleted resources if and when available
- Processes to replace outdated supplies
- Financial processes for the reimbursement of depleted resources based on the type of incident (e.g., emergency declaration) or through routine processes
- A process to identify resource gaps and corrective actions for future improvement

E1: (*Based on priorities and needs*) Inventory management system:

The State and Healthcare Coalitions, in coordination with healthcare organizations, have or have access to a process and/or system with the ability to track and record resources that are available and shared among the healthcare community. This may be executed in coordination with agencies that have inventory systems.

Function 4: Demobilize and evaluate healthcare operations

Required Resource Elements:

P1: (*Required*) Resource demobilization:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a coordinated plan for demobilization procedures that assists healthcare organizations with returning resources or releasing staff. These procedures should include but are not limited to the following elements:

- Coordination with incident command
- Processes to provide healthcare organizations with general information regarding the demobilization effort
- Healthcare organization responsibilities/agreements for reconditioning equipment/resources
- Healthcare responsibilities associated with applying the demobilization plan
- Processes to provide healthcare organizations with information regarding general release priorities for resources (i.e., resource type or equipment)

P2: (*Required*) Evaluation and continuous program improvement:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, participate in coordinated process to evaluate response operations and incorporate best practices and lessons learned into the continuous improvement process for corrective action. This should include but is not limited to the following elements:

- Input into After Action Reports
- Development of corrective action plans
- Follow up on corrective actions for preparedness activities (planning, equipping, training, and exercising)
- Includes corrective actions during the course of an incident or event

For supporting information, please see Capability 1: Healthcare Preparedness

S1: (*Based on priorities and needs*) Evaluation training:
The State and Healthcare Coalitions, in coordination with healthcare organizations, coordinate training that provides the knowledge, skills, and abilities associated with the evaluation process. This training is determined by the unique needs of the individual healthcare organizations, the Healthcare Coalition, and the State.

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during periods of increased deaths at healthcare organizations during an incident.

Associated Performance Measures:

- HPP Specific Measure #4: **Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities.**
    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

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Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations

Required Resource Elements:

P1: (*Required*) Anticipate storage needs for a surge of human remains:

The State and Healthcare Coalitions, in coordination with healthcare organizations, public health, and emergency management, participate in risk assessments to estimate the number of deaths that may occur during an incident, to anticipate the need for storage of human remains.

P2: (*Required*) Healthcare organization human remains surge plans:

The State, in coordination with Healthcare Coalitions, healthcare organizations, local and state emergency management, ESF #8, and agencies responsible for fatality management, participate with the development of plans that assist healthcare organizations with the storage of human remains resulting from a surge of deaths during an incident. This plan should include but is not limited to the following elements:

- Protocols that coordinate the need for human remain storage with fatality management operations ongoing in the community

- Protocols for interaction with local fatality management authorities
- Coordination with lead and support agencies to assist with the immediate and temporary storage of human remains for healthcare organizations
- Development of resource request processes for alternate storage (e.g., use of alternate morgue locations within the local jurisdiction)
- Request and transportation processes for assets that provide additional storage (e.g., refrigerated trailers, mobile mortuary system)
- Resources available through mutual aid agreements
- Processes to request state and Federal resources (e.g., State/Disaster Mortuary Operational Response Teams)
- Protocols that ensure culturally sensitive and legal storage for human remains

E1: (*Based on priorities and needs*) Mortuary storage equipment and supplies:

The State, in coordination with Healthcare Coalitions, healthcare organizations, local and state emergency management, ESF #8, and agencies responsible for fatality management, assess the need for assets to store human remains. This should be based on anticipated death estimates identified during planning and risk assessment development. This type of equipment should comply with the requirements, regulations, and laws of the State and be able to provide culturally sensitive storage.

Function 2: Coordinate surges of concerned citizens with community agencies responsible for family assistance

Required Resource Elements:

P1: (*Required*) Procedures for a surge of concerned citizens:

The State, in coordination with healthcare organizations, Healthcare Coalitions, Emergency Management, and agencies responsible for providing family assistance during mass fatalities, participate in planning to develop a plan that can assist healthcare organizations in the case of a surge of concerned citizens requesting information about missing family members. Consideration should be given to the inclusion of the following elements:

- Obtain guidance from the responsible agency for family support in the community that can provide the following information:
    - Locations of family assistance centers (as related to mass fatality) or coordination with family reception centers (if no FAC is operational)
    - Protocols to ensure healthcare organizations can connect with family assistance centers

Function 3: Mental/behavioral support at the healthcare organization level

Required Resource Elements:

P1: (*Required*) Mental/behavior health support:

The State, in coordination with healthcare organizations and the agencies responsible for mental/behavioral health, participate in coordinated planning to develop processes for healthcare organizations that would assist them with the procedures to request mental/behavioral health support that could be made available to responders, survivors, and families. This is for assistance beyond that of a healthcare organizations ability to provide. This could include but is not limited to the following elements:

- The processes for healthcare organizations to interact with mental/behavioral health professionals of the community and request support to assist with the mental/behavioral needs of their staff including psychological first aid
- A contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the nature of the incident. Consideration should be given to the inclusion of the following elements:
    - Mental/behavioral health professionals
    - Spiritual care providers
    - Hospice
    - Translators
    - Embassy and Consulate representatives when international victims are involved

Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of public health and medical related information and situational awareness between the healthcare system and local, state, Federal, tribal, and territorial levels of government and the private sector. This includes the sharing of healthcare information through routine coordination with the Joint Information System for dissemination to the local, state, and Federal levels of government and the community in preparation for and response to events or incidents of public health and medical significance.

Associated Performance Measures:

- HPP-PHEP Measure #6: Proportion of local health departments that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs) and healthcare coalitions (HCCs)

- **HPP Specific Measure #7: Percent of healthcare coalitions (HCCs) that can continuously monitor Essential Elements of Information (EEIs) and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture**

    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture

Required Resource Elements:

P1: (*Required*) Healthcare information sharing plans:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain coordinated and integrated information sharing plans. Coordinated information sharing plans should include processes to:

- Identify protocols for healthcare organizations to provide multi-agency coordination of information to and from the ESF #8 liaison/ incident management (e.g., Healthcare Coalition assistance or some other process to represent healthcare organizations)
- Establish the protocols for healthcare organizations to provide and receive timely, relevant, and actionable information that can be used to:
    - Assist with the creation of an incident common operating picture that provides information about the operating status of healthcare organizations and their immediate resource needs
    - Inform local, state and/or the Federal incident management and other relevant response partners about healthcare organization resource needs to assist with the decisions regarding resource allocation
    - Inform healthcare organizations with relevant incident information and status of healthcare delivery operations within the community(e.g., available resources)

P2: (*Required*) Healthcare essential elements of information:
The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and

stakeholders, determine reportable healthcare incident specific information to be used during the response. This information identifies the essential elements of information that can be reasonably shared during an incident. The process should enable the sharing of timely, relevant and actionable information during response that assists incident management with decisions to provide healthcare organizations with immediate resource needs. This information should be coordinated and agreed upon by healthcare organizations and local, state and Federal response partners. Guidelines for these elements should ensure information is incident specific, timely, relevant, actionable, and flexible enough so that appropriate response decisions can be executed.

Minimal information requirements should include but are not limited to the following elements:

- Elements of information that is coordinated and agreed upon by healthcare organizations and local, state, and Federal response partners
- The types of information that can be shared
- The frequency that information should be shared
- Participants authorized to receive and share data
- Data use and re-release parameters
- Data protections
- Legal, statutory, privacy, and intellectual property considerations
- Information system security (ISS)

Examples of types of information to consider when defining reportable elements can include:

- Facility operating status
- Facility structural integrity
- The status of evacuations/shelter in-place operations
- Critical medical services (e.g., trauma, critical care)
- Critical service status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
- Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supplies, and medical equipment)
- Staffing status
- Emergency Medical Services (EMS) status involving patient transport, tracking, and availability
- Other information as applicable or determined through coordination

P3: (*Required*) Healthcare incident information validation:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to validate healthcare incident information according to requested response needs. Coordinated information sharing plans should identify an active validation process to confirm healthcare organization status and requests during an incident. Validation procedures should occur when inconsistencies with established reporting mechanisms have been identified (e.g., no report when expected, rumors of distress, etc.). The validation is completed by a process or system as a redundant situational awareness mechanism to confirm the status of the healthcare organizations' needs.

P4: (*Required*) Healthcare information sharing with the public:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to coordinate relevant healthcare information for public information sharing. Information sharing processes should coordinate relevant healthcare information with the Joint Information System (JIS) to ensure public information is disseminated and accurate (e.g., "one voice"). This type of information includes but is not limited to the following elements:

- The effects of the incident on the healthcare delivery system
- The current status of healthcare organizations
- Healthcare service messages to the public (e.g., where outpatient services are located, hours of operation, emergency department wait times, alternate facility options)
- Other appropriate information

For supporting information, please see PHEP Capability 4 — Early Public Information and Warning.

E1: (*Required*) Healthcare information systems:

The State and Healthcare Coalitions, in coordination with healthcare organizations, should have or have access to information sharing system(s) that assist with the creation of an incident common operating picture. These systems should have the ability to:

- Integrate with local or state emergency operations information systems used for response
- Provide timely, relevant, and actionable healthcare information to the incident common operating picture
- Provide multijurisdictional and multidisciplinary incident related information to healthcare organizations

- Adhere to applicable local and state information technology regulations regarding the receipt and transmittal of information

Examples of information sharing systems that contribute to the incident common operating picture include but are not limited to the following:

- Bed tracking systems
- EMS information systems
- Health alert networks
- Patient tracking systems
- 911 call centers and systems
- Web-enabled emergency management communications systems
- Credentialing systems

P5: (*Required*) Bed tracking:

The State and Healthcare Coalitions, in coordination with healthcare organizations, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain processes to electronically track bed status from healthcare organizations. These processes should:

- Provide information on the bed status of the healthcare delivery system
- Provide insight into the ability of the healthcare organization to accept a surge of patients (This is dependent on preplanning accuracy of surge and capacity estimates and current available data from healthcare organizations [e.g., number of available beds, number of beds that can be used based on resources, and contingency plans for surge that are in effect])
- Bed tracking processes may be an automated electronic system with the redundant system being a manual reporting process
- Integrate information into the incident common operating picture
- Assist incident management and healthcare entities with decisions regarding resource allocation, anticipated requests for assistance, and transport decisions

E2: (*Required*) Bed tracking system:

The State and Healthcare Coalitions, in coordination with healthcare organizations, relevant response partners, and stakeholders, should have or have access to a bed tracking system. Systems should have the ability to:

- Provide information on the availability of bed status
- Provide a picture of the healthcare delivery area surge status
- Update bed status based on the situation and availability

- Report aggregate bed tracking data
- Report on pre-identified bed categories*

S1: (*Based on priorities and needs*) Bed tracking system training:

The State and Healthcare Coalitions, in coordination with healthcare organizations, provide bed tracking system training. System training should be based on the identified needs of the healthcare organizations.

P6: (*Based on priorities and needs*) Patient tracking:

The State and Healthcare Coalitions, in coordination with EMS, healthcare organizations, and emergency management, develop, refine, and sustain a process to track patients and/or have access to an electronic patient tracking system during an incident. This should include but is not limited to the ability to:

- Identify system users that have the appropriate authority/access permissions for electronic systems
- Access relevant and available aggregate patient tracking data from EMS and healthcare organizations (e.g., number of patients requiring receiving facilities, requiring transfer services)
- Integrate the aggregate patient tracking data into the local, state and/or Federal incident common operating picture
- Adhere to applicable patient confidentiality laws, regulations, and policies
- Integrate with the Federal patient tracking system of record

Note: "…Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These may include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services."

E3: (*Based on priorities and needs*) Patient tracking system:

The State and Healthcare Coalitions, in coordination with EMS and healthcare organizations, should have or have access to a patient tracking system. The system should have the ability to:

- Maintain operational status during an incident
- Integrate with the Federal patient tracking system of record
- Satisfy applicable confidentiality requirements
- Track patients from entry into the healthcare system (EMS or facility level) through discharge

- Integrate data into the local, state and Federal incident common operating picture

P7: (*Based on priorities and needs*) Patient record tracking:

The State, in coordination with Healthcare Coalitions, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a process to access an information infrastructure and exchange system that provides electronic medical healthcare information during response, if available and authorized. This process should include but is not limited to the following elements:

- Guidance that ensures information is available to assist with the continuity of care for patients immediately post-incident
- Identification of those who have authority/permissions to use the information during an incident
- Methods that ensure providers can access relevant electronic medical healthcare information, when it is available

Note: "…Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These may include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services."

Function 2: Develop, refine, and sustain redundant, interoperable communication systems

Required Resource Elements:

P1: (*Required*) Interoperable communications plans:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain coordinated communications plans. These plans should include processes to:

- Provide interoperable communications
- Communicate between healthcare organizations and on-scene incident management
- Communicate between healthcare organizations and local, state, and Federal ESF #8 and emergency operation centers
- Enable healthcare organizations to communicate with other healthcare entities' communication systems (e.g., hospitals, EMS, Long-Term Care)

- Provide redundant communications
- Restore emergency communications
- Contact the ESF #8 liaison and incident management when electronic systems are inoperable
- Include legal, privacy, and intellectual property considerations
- Include information system security (ISS)
- Coordinate healthcare organization(s) emergency communications with statewide interoperability coordination and regional emergency communications coordination
- When appropriate, incorporate alternate forms of communication (e.g., social media)

E1: (*Required*) Interoperable communication system:

The State and healthcare organizations, in coordination with Healthcare Coalitions, relevant response partners, and stakeholders, have or have access to redundant, interoperable communications systems. These systems must be capable of communicating vertically with local, state, and Federal incident management and ESF #8, and horizontally with critical healthcare response partners in the community. Communication upgrades should be based on the most current Federal Communications Commission regulations: http://www.fcc.gov/topic/emergency-communications

Examples of redundant communications include but are not limited to:

- Landline and cellular telephones
- Two-way VHF/UHF radio
- Satellite telephones
- Amateur (HAM) radio

Consider the use of emergency restoration programs. Examples of these include but are not limited to:

- Emergency Telecommunications Programs: http://transition.fcc.gov/hspc/emergencytelecom.html
- Priority Communication Services: http://transition.fcc.gov/pshs/emergency/priorityservices.html
- Telecommunication Service Priority (TSP): http://transition.fcc.gov/pshs/emergency/telecom.html
- Government Emergency Telecommunications Service (GETS): http://transition.fcc.gov/pshs/emergency/gets.html
- Wireless Priority Services (WSP): http://transition.fcc.gov/pshs/emergency/wps.html
- Fact sheets: http://transition.fcc.gov/hspc/factsheets.html

S1: (*Based on priorities and needs*) Communication training:

Communication training should be coordinated by the State, Healthcare Coalition, and the healthcare organization with the appropriate input from communication subject matter experts. Training curriculums should be based on:

- Communication training needs of the healthcare organization
- Emergency communication systems provided to the healthcare organization (both the primary and redundant systems)
- Information exchange protocols related to the exchange of information during emergency communication and the legal restrictions that are applicable to the State

Capability 10: Medical Surge

Definition: The Medical surge capability is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community. This encompasses the ability of healthcare organizations to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.

Associated Performance Measures:

- HPP Specific Measure #9: Percent of healthcare coalitions that have a coordinated mechanism established that supports their members' ability both to deliver appropriate levels of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients), as well as to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster

    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge

Required Resource Elements:

P1: (*Required*) Healthcare Coalition preparedness activities:

The Healthcare Coalition, in coordination with the State, healthcare organizations, emergency management, Emergency Support Function (ESF) #8, relevant response partners, and stakeholders, develop, refine, and sustain medical surge

plans for healthcare system preparedness. These plans should include, but are not limited to the following elements:

- Multi-agency coordination between healthcare organizations and emergency management to ensure healthcare organization medical surge priorities and needs are addressed in local and state all-hazards plans
- Coordination and integration of medical surge preparedness activities with healthcare organizations, relevant response partners, and stakeholders
- Coordination of medical surge training and exercises planned at the local or regional level by the Healthcare Coalition
- Coordination of regionally controlled surge resources if available
- Assistance with improvement planning for healthcare organizations' medical surge preparedness, response, and recovery capabilities
- Development of processes to enhance the regional surge capacity and capability of the healthcare delivery system
- Development of information and resource assistance strategies with the State and other partners to assist healthcare organization surge operations during a response

For supporting information, please see Capability 1 -— Healthcare Preparedness

P2: (*Required*) Multi-agency coordination during response:

The State and the Healthcare Coalition, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to ensure healthcare organizations are represented in incident management decisions during medical surge incidents. These plans should have processes that:

- Guide healthcare organization coordination and integration with ESF #8
- Guide healthcare organization coordination and integration with incident management at the Federal, state, local, tribal, and territorial government levels
- Assist with healthcare organization information sharing procedures during medical surge operations (For supporting information, please see Capability 6 – Information Sharing)
- Assist with healthcare organization resource coordination during medical surge operations (For supporting information, please see Capability 3 – Emergency Operations Coordination)

Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations

Required Resource Elements:

P1: (*Required*) Healthcare organization coordination with EMS during response:

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan that includes processes to coordinate information sharing and surge resources. These processes should ensure the ability to:

- Provide ongoing communication to healthcare organizations about EMS activity during surge operations
- Coordinate transport decisions vertically and horizontally during medical surge incidents
- Provide healthcare organizations with situational awareness about the status of the transport and tracking of patients from EMS
- Provide situational awareness of healthcare organizations' patient receiving status that assists with coordination for pre-hospital transport decisions (e.g., primary and alternate facility receiving status/availability)
- Assist healthcare organizations to notify local, state or regional (Healthcare Coalition) personnel to request support
- Contact relevant EMS agencies within the region
- Inform EMS of bed status when requested (if not electronically available)
- Assist EMS and healthcare organizations make decisions to divert en route EMS facilities with the equivalent levels of care based on bed status and patient tracking information
- Provide equal access for the transport of at-risk individuals and those with special medical needs
- Assist with the implementation of existing statewide mutual aid plans to deploy EMS units in jurisdictions/regions they do not normally cover, in response to a mass casualty incident

P2: (*Required*) Coordinated disaster protocols for triage, transport, documentation, CBRNE:

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to assist with training and guidance to understand the local disaster EMS protocols for triage, transport, documentation, and decontamination. Plans may include but are not limited to the following elements:

- Coordination with local and/or state EMS medical direction/oversight to ensure the most current guidance regarding EMS disaster triage, transport, and CBRNE treatment is provided to healthcare organizations to include:
    - Triage methodologies
    - Protocols for:

        - Transport of mass casualties during medical surge (e.g., transport patients from an incident scene or from local hospitals to healthcare facilities in adjacent jurisdictions within or near the affected jurisdiction, and to nearby staging areas for transport to more distant healthcare facilities)
        - Disaster documentation during incident
        - CBRNE exposure care
    - A process for the promotion and dissemination of EMS protocols and methodologies to healthcare organizations
    - Development of coordinated training and exercises between EMS and healthcare organizations

S1: (*Based on priorities and needs*) Training on local EMS disaster triage methodologies:

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need to provide training for healthcare organizations that includes the local EMS disaster triage methodology. Training should focus on developing a common understanding of critical operations between the healthcare organization and EMS.

S2: (*Based on priorities and needs*) Coordinated CBRNE training:

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need to provide training for healthcare organizations that includes the local EMS CBRNE protocols. Training should focus on developing a common understanding of critical operations between the healthcare organization and EMS.

Function 3: Assist healthcare organizations with surge capacity and capability

Required Resource Elements:

P1: (*Required*) Medical surge planning:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, coordinate plans to ensure the priorities and needs of healthcare organizations are addressed in the local and state emergency operations plans. Coordinated medical surge plans should include but are not limited to the following:

- Processes to assess and maximize surge capability and capacity of healthcare organizations in the community (For more information, please see Capability 1 — Healthcare Preparedness)
- Strategies for surge planning, training, exercising, and securing equipment to assist healthcare organizations respond to a medical surge incident
- Validation of healthcare organization surge plans operability
- Processes to shorten response times to assist healthcare organizations with activation of medical surge plans
- Processes to ensure multi-agency coordination of resource decisions during medical surge operations
- Protocols for the sharing of medical surge specific information between incident management, healthcare organizations, and stakeholders in the community
- Protocols for the management of assistance with healthcare organization surge resources should include:
    - Resource request process from local incident management
    - Processes to allocate locally or regionally controlled assets if available
    - Assistance with the implementation of other resource processes when requested
- Crisis standards of care guidance for healthcare organizations to assist with treatment decisions for a surge of casualties during periods of minimal or scarce resources (For supporting information, please see Function 4 — Crisis Standards of Care)
- State led processes to contact the local, state or Federal volunteer agencies, the ESF#8 liaison and incident management to coordinate volunteer assistance, including those involving health professionals (For supporting information, please see Capability 15 — Volunteer Management) and Federal NDMS teams.

P2: (*Required*) Medical surge emergency operations coordination:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan for healthcare organizations to provide multi-agency coordination for information sharing and resource decisions that assist healthcare organizations during surge operations. These decisions require real-time, multi-agency coordination that represent healthcare organizations, or by plans that ensure incident management is informed before making resource decisions affecting healthcare organizations.

For supporting information, please see Capability 3 — Emergency Operations Coordination

P3: (*Required*) Assist healthcare organizations maximize surge capacity:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners and stakeholders, develop, refine, and sustain a plan to maximize surge capacity for medical surge incidents. This plan may include but is not limited to the following elements:

- Surge Assessment:
    - Pre-incident assessment of normal operating capacity for healthcare organizations within the healthcare delivery area
    - Pre-incident estimate of surge casualties (i.e., medical casualties, mental/behavioral health casualties)[estimates are based on the risk assessment — For more information, please see Capability 1 – Healthcare Preparedness]
    - Pre-incident assessment of available resources to address surge estimates
    - Development of surge capacity indicators that would trigger different aspects of the medical surge plan (e.g., surge in place strategies; early discharge, cancelled elective surgeries; augmented personnel; extra shifts, volunteers; established alternate care sites or activated mobile units; requested mutual aid)
    - Processes to immediately identify an increase in medical surge status during an incident (e.g., medical, mental/behavioral health, concerned individuals)
- Decompression (clear) of critical beds:
    - Develop, refine, sustain, and implement processes that assist healthcare organizations with daily, continuous, triage of admitted patients and discharge planning to permit the safe discharge of less acute patients, ensuring twenty percent acute bed availability in the event of a disaster
    - Coordination with non-acute care facilities to accept patients to clear beds (e.g., Community Health Centers, SNFs, and home healthcare)
    - State led coordination with Veterans Health Administration and Department of Defense to establish options for assistance with patient care, transfer of patients, and additional assistance during medical surge operations
    - Development of viable options to share healthcare assets (e.g., beds, staffing, equipment) between healthcare organizations

    - Protocols to request immediate resources needed to decompress beds (e.g., transport, staffing, space, equipment and supply needs)
    - Develop, refine, and sustain patient movement options to address psychiatric beds, involuntary holds, and patients with exposure to CBRNE
- Locally available resource assistance (mobile equipment and caches of supplies):
    - Implementation of state or regional resource assistance (if available) to include plans to deploy mobile medical assets and utilize caches of medical supplies
- Alternate surge sites (healthcare organization or Healthcare Coalition):
    - Protocols to assist with activation of alternate surge sites if requested by the healthcare organization. This may include the following elements:
        - Processes to supply surge tents or trailers and equipment to serve as additional treatment areas for patients when available (e.g., mobile hospital)
        - Processes to assist healthcare organizations request staffing to operate surge sites when requested and available (e.g., mobile medical team)
        - Coordination of alternate surge sites with state and local EMS authorities to ensure these sites can receive and transfer EMS ambulance patients
        - Coordination of assets requested through the Emergency Management Assistance Compact
        - Coordination of Federal assets (e.g., Federal Medical Stations, Disaster Medical Assistance Team)
- Alternate care sites:
    - Coordination with alternate care sites developed at non-healthcare facilities for the surge of individuals that do not require care at healthcare organizations' surge sites
- Mass death in healthcare facilities:
    - Coordination with fatality management planning to address mass deaths and the ability to store human remains that occur at healthcare facilities (For supporting information, please see Capability 5 – Fatality Management)
    - Coordination of planning to address surges of concerned citizens at healthcare facilities that may occur during community mass fatalities (For supporting information, please see Capability 5 – Fatality Management)
- Volunteers and other staff resources:

    - Develop, refine, and sustain processes that assist healthcare organizations to share staff during medical surge operations. This includes the credentialing process prior to an incident
    - Implementation of plans to utilize the local volunteer management process to gain access to trained, credentialed staff to assist with patient care and other duties during surge operations (For more information, please see Capability 15: Volunteer Management)
- Crisis standards of care:
    - State led processes to guide healthcare organizations during crisis standards of care when resources are scarce and when requested (For supporting information, please see Function 4 in Capability 10)

Note: Maximum facility surge capacity is the provision the highest level that can be provided to patients in the available beds that can be staffed and also have the required resources for care. This is guided by risk assessments and gap analysis regarding the estimated surge.

P4: (*Required*) Assist healthcare organizations maximize surge capability:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to maximize surge capability for medical surge incidents. This plan should include but is not limited to the following elements:

- Processes for providing specialized medical evaluation and care:
    - Assistance to healthcare organizations with the management of patients requiring unusual or specialized medical evaluation and care. This may include:
        - Process to obtain specialized resources that are not routinely available to the healthcare organization (e.g., burn, pediatric, trauma resources)
        - Coordination with healthcare organizations to identify subject matter expertise (e.g., pediatric, neurology, trauma) that would be requested to assist with special medical evaluation and care
        - Coordination with healthcare organizations to identify services or supplies that would be requested to assist with identified bottlenecks for care such as:
            - Radiology services
            - Critical care services
            - Surgical services
            - Special medical support (e.g., pharmacy, blood)

        - Coordinated processes to request specialty medical teams and equipment (e.g., state and local medical assistance teams, National Disaster Medical Assistance (NDMS) Teams, and Federal Medical Stations)

- Processes to provide assistance with decontamination, isolation, and quarantine:
    - Processes to assist healthcare organizations with special interventions to protect medical providers, other patients, and the integrity of the healthcare organization when there is a surge of patients with conditions that require decontamination, isolation or quarantine. These interventions may include (if available and requested):
        - Coordination for extra Personal Protective Equipment (PPE)
        - Coordination for extra decontamination resources
        - Coordination for state or regionally located caches of pharmaceuticals
        - Processes to contact the responsible public health agency tasked with isolation and quarantine when there is a surge of patients requiring these interventions

P5: (*Required*) Medical surge information sharing:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a process to provide healthcare organizations with ongoing communication regarding the status of medical surge operations. This includes incident status, surge status (e.g., bed availability, patient tracking, and surges of concerned individuals), availability of resources, and healthcare organization operating status.

For more information, please see Capability 6 — Information Sharing

P6: (*Required*) Healthcare organization patient transport assistance:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain patient transport processes for medical surge incidents. These processes address patient transport needs above routine healthcare organization transport agreements due to the number and severity of patients. The methods used to transport may vary, however, the medical and legal obligations for patient transport should be considered and factored into transportation processes. The coordination of multiple transport options include but are not limited to following considerations:

- Air, ground, and sea options

- Public and private options
- National guard collaboration
- Federal Coordinating Centers (FCC) and National Disaster Medical System collaboration (e.g., coordination with FCC to establish patient movement protocols between the private sector and the Federal patient movement system)
- Volunteer agencies
- Family members
- Additional innovative options (just-in-time options)

Transportation processes should be consistent with applicable laws, regulations, and policies:

- Emergency Medical Treatment and Active Labor Act (EMTALA) and
- The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

P7: (*Required*) Medical surge considerations for at-risk individuals and those with special medical needs:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, participate in planning for at-risk individuals and those with special medical needs for medical surge incidents. This includes those at-risk patients requiring medical treatment at a healthcare facility that may contribute to medical surge (e.g., dialysis patients, home care ventilator patients).

E1: (*Based on priorities and needs*) Specialty equipment to increase medical surge capacity and capability:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need for equipment to assist with the existing capacity and capability. This type of equipment may include but is not limited to:

- Equipment and supplies, including operational plans, that assist healthcare organizations to manage increased number of patients (medical surge capacity) such as:
    - Equipment to expand space (e.g., tents, mobile medical assets)
    - Medical equipment to support a surge of patients
    - Additional patient care supplies
- Equipment, including operational plans, that assists with the provision of specialized medical evaluation and care (medical surge capability) such as:
    - Specialty care equipment (e.g., pediatric, burn, and trauma care equipment and supplies)
    - Mobile assets to supply services (e.g., radiology, pharmacy)

    - Additional types of equipment and supplies for specialized surge services

S1: (*Based on priorities and needs*) Special training to maximize medical surge competency:

The State and Healthcare Coalitions, in coordination with healthcare organizations, provide training to develop, refine, and sustain medical surge capabilities. This may include training that is a based on an existing need and determined by pre-defined priorities of the healthcare organizations and the State. Examples of this type of training may include:

- Burn, trauma, and pediatric training to enhance the specialty capabilities for providers in facilities that do not regularly care for these types patients
- Additional types of training to enhance the specialty capabilities to treat types of patients not routinely cared for but encountered during a disaster

P8: (*Based on priorities and needs*) Mobile medical assets for surge operations:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain plans for using mobile medical assets during medical surge operations. These plans should include but are not limited to the following elements:

- Operational plans for mobile medical assets to include:
    - The parameter of care delivered in the mobile platform (e.g., acute vs. non-acute; pediatric vs. adult)
    - Location (e.g., healthcare organization, local, and regional)
    - Operational timeframe
    - Required resources (equipment, staffing, supplies, transportation, and utilities)
    - Movement procedures of assets during an incident or event
    - Maintenance of assets
    - Supply and resupply of assets
    - The management of staff during a surge incident
    - Training
    - Communications
    - Additional relevant resources to include Federal NDMS teams.
- Protocols to request mobile medical assets from the local, state or Federal incident management

E2: (*Based on priorities and needs*) Mobile Medical Assets:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need for the procurement and use of mobile medical assets to be strategically located in the local or regional area, for use by healthcare organizations. These assets should have the ability to increase medical surge capacity and capability and include an operational and sustainment plan. Types of mobile medical assets may include but are not limited to:

- Mobile staff (mobile teams of healthcare professionals)
- Mobile caches of equipment and/or supplies
- Mobile trailers or shelters to provide:
    - Space for treatment of patients (e.g., mobile hospital, Federal Medical Stations)
    - Space for storage of surge equipment
    - Resources for emergency communications
    - Other viable surge uses

P9: (*Based on priorities and needs*) Decontamination assistance to healthcare organizations:

The State and Healthcare Coalitions, in coordination with healthcare organizations, Hazardous Materials (HazMat) response authorities, ESF #8, and relevant response partners, develop, refine, and sustain decontamination plans to provide assistance during incidents that overwhelm the existing decontamination ability of the healthcare organization. Plans should include but are not limited to the following elements:

- Assessments of the decontamination capability of healthcare organizations
- Assessments of the anticipated number of casualties resulting from a CBRNE exposure that are expected to seek treatment at healthcare organizations without prior decontamination (based on local risk assessments)
- Develop, refine, and sustain strategies to provide assistance to healthcare organizations with decontamination planning, equipping, or training to meet the anticipated need
- Processes to request decontamination assets during response, if available
- Coordination with local EMS decontamination units and HazMat units to support decontamination surges that overwhelm healthcare organizations
- Processes to coordinate healthcare organization decontamination procedures with state, regional and local HazMat response teams
- Processes for healthcare organizations to return assets that were provided (e.g., cleaning, resupply)

E3: (*Based on priorities and needs*) Decontamination assets:

The State and Healthcare Coalitions, in coordination with healthcare organizations, and HazMat response authorities, assess the need for the use of decontamination assets and strategically locate them in the local or regional area, for use by healthcare organizations. These assets should have the ability to:

- Decontaminate more than one patient simultaneously
- Decontaminate both ambulatory and stretcher patients
- Include provisions for at-risk individuals and those with special medical needs

Decontamination assets should have operational plans that include:

- Request processes
- Location of assets (e.g., healthcare organization, local, or regional [Healthcare Coalition])
- Operational timeframe to deploy
- Movement procedures of assets during an incident or event
- Required resources (equipment, staffing, supplies, transportation, and utilities)
- Maintenance of assets
- Supply and resupply of assets
- The management of staffing during a surge incident
- Training plans including just-in-time training plans for new healthcare workers assigned to use the asset
- Additional relevant resources

S2: (*Based on priorities and needs*) Decontamination training:

The State and Healthcare Coalitions, in coordination with healthcare organizations and HazMat response authorities, provide decontamination training that may include but is not limited to the following elements:

- Training of the local or state approved decontamination methodology
- Decontamination training that has been coordinated through the appropriate subject matter expert agencies
- Assistance to healthcare organizations in the proper use of their decontamination equipment
- Training on decontamination equipment that may be available for healthcare organization response operations (i.e., training should include procedures for implementation, maintenance, and operational guidance to help healthcare personnel use the asset)

P10: (*Required*) Mental/behavior health support:

The State, in coordination with healthcare organizations and the agencies responsible for mental/behavioral health, participate in coordinated planning to develop processes for healthcare organizations that would assist them with the procedures to request mental/behavioral health support during medical surge incidents that could be made available to responders, survivors, and families. This is for assistance beyond that of a healthcare organizations ability to provide. This could include but is not limited to the following elements:

- The processes for healthcare organizations to interact with mental/behavioral health professionals of the community and request support to assist with the mental/behavioral needs of their staff including psychological first aid
- A contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the incident. Consideration should be given to the inclusion of the following elements:
    - Mental/behavioral health professionals
    - Spiritual care providers
    - Hospice
    - Translators
    - Embassy and Consulate representatives when international victims are involved

Function 4: Develop Crisis Standards of Care guidance

Required Resource Elements:

P1: (*Required*) State crisis standards of care guidance:

States should develop collaborative crisis standards of care guidance by actively engaging Healthcare Coalitions, healthcare organizations, healthcare practitioners, and local and state medical and public health authorities. There are five key elements to include in the development the guidance:

- A strong ethical grounding
- Integrated and ongoing community and provider engagement, education, and communication
- Assurances regarding legal authority and environment
- Clear indicators and roles and responsibilities
- Evidenced-based (informed) clinical processes and operations

P2: (*Required*) Indicators for crisis standards of care:

The State, in coordination with healthcare organizations, Healthcare Coalitions, and public health and medical authorities, provides guidance to assist healthcare organizations with crisis standards of care plan development to include indicators for crisis standards of care. Components to consider in the guidance include:

- Identification of the progressive indicators that lead to crisis standards of care (these are general and will vary state by state, use Institute of Medicine (IOM) guidance for assistance):
    - Recognition of a surge above the normal operating capacity of the healthcare system during a disaster
    - Recognition of a depletion of the healthcare system's resources to a pre-identified critical threshold of resource availability that warns of impending resource exhaustion including but not limited to:
        - Critical Infrastructure (essential services) availability
        - Staffing availability
        - Equipment and supply availability
        - Patient care space availability
    - A plan to discontinue specific patient care services or optimize existing services before resources are at critical levels or exhausted (e.g., elective procedures, primary care)
    - A plan to implement crisis standards of care operations and begin the discontinuation of critical services when resources are no longer available

P3 (*Required*) Legal protections for healthcare practitioners and institutions:

The State, in coordination with healthcare organizations, Healthcare Coalitions, and public health and medical authorities, identifies the legal protections for public health and healthcare practitioners prior to crisis standards of care implementation. These may include the following (dependent on the State government):

- The scope and breadth of emergency declarations and ensuing powers to respond
- Medical and legal standards of care
- Legal authorization to allocate personnel, resources, and supplies
- Licensure reciprocity and scope of practice limitations
- Risks of liability and available liability protections (e.g., Federal Volunteer Protection Act, Federal PREP Act, applicable state laws, etc.) for public health and healthcare practitioners and institutions
- Legal issues related to the deployment and use of volunteer health practitioners
- Special waivers or modifications of key statutory and/or regulatory requirements that may apply during emergencies (declared or otherwise)

(e.g., if CMS issues waivers or modifications under section 1135 of the Social Security Act)

- FDA issuance of emergency use authorizations for non-approved drugs or devices

P4: (*Required*) Provide guidance for crisis standards of care implementation processes:

Crisis standards of care processes and/or plans should include but are not limited to the following elements:

- Indicators for crisis standards of care
- Implementation criteria for elements such as:
    - Triage operations
    - Clinical care in disasters
    - Disaster mental/behavioral health
    - Palliative care planning
    - Pre-requisite command, control, and coordination elements
    - Decision tools and resource use guidance

P5: (*Required*) Provide guidance for the management of scarce resources:

Crisis standards of care resource allocation planning should be coordinated by the State, the Healthcare Coalition, and local medical and public health authorities to develop guidance based on state laws and regulations. This guidance should assist healthcare organizations to develop strategies for resource management during crisis standards of care. Recommended strategies may include but are not limited to processes that:

- Reduce resource demand such as:
    - Cancelling elective surgeries and outpatient appointments
    - Directing public to shelter-in-place locations
- Optimize existing resources such as:
    - Use of non-healthcare providers for certain roles
    - Adjusting triage techniques
    - Balancing and re-distributing patient loads across the different healthcare organizations
    - Re-purposing existing resources
- Augment existing resources such as:
    - Substituting effective alternatives
    - Implementing mutual aid agreements
    - Utilizing alternate care sites
    - Utilizing volunteers

- Provide guidance for palliative care such as:
    - Means to provide pain management and comfort to those dying during a disaster
    - Reassessment protocols for palliative care patients to determine if resources can be made available for their care
- Include strategies to address specific types of resource shortages such as:
    - Ventilators and components
    - Oxygen and oxygen delivery devices
    - Vascular access devices
    - Pediatric equipment and supplies
    - Intensive care unit (ICU) beds
    - Healthcare providers, particularly critical care, burn, pediatric, surgical/ anesthesia staff (nurses and physicians), and respiratory therapists
    - Hospitals (due to infrastructure damage or compromise)
    - Specialty medications or intravenous fluids (sedatives/analgesics, specific antibiotics, and antiviral)
    - Vasopressors/inotropes
    - Medical transportation
- Example strategies to address resource shortages include: Substitution (e.g., narcotic substitution)
    - Conservation (e.g., oxygen flow rates titrated to minimum required)
    - Adaptation (e.g., anesthesia machines used for mechanical ventilation)
    - Reuse of supplies (e.g., reuse nasogastric tubes and ventilator circuits after appropriate disinfection)
    - Reallocation (e.g., relocates oxygen saturation and cardiac monitors for use with multiple patients with critical illness or those patients with borderline conditions to ensure their condition does not worsen; remove patients from ventilators who are unlikely to survive and use the ventilator for patients with the greatest chance of survival)
- Example strategies for EMS agencies to address shortages:
    - Alternate dispatch options (e.g., assign EMS to only life-threatening calls by pre-determined criteria; no response to cardiopulmonary resuscitation-in-progress calls)
    - Staffing adjustments (e.g., adjust shift length and the number of individuals who will respond)
    - Response alternatives (e.g., decline service to non-critical, non-vulnerable patients)

S1: (*Required*) Crisis standards of care training:

The State, in coordination with healthcare organizations, Healthcare Coalitions, and public health and medical authorities, provide training for crisis standards of care that should include but is not limited to following elements:

- Multi-agency coordination of planning efforts related to crisis standards of care and the allocation of scarce resources
- The legal protections specific to local or state healthcare
- Training aids for Healthcare Coalitions and healthcare organizations related to crisis standards of care

Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations

Required Resource Elements:

P1: (*Required*) Healthcare organization evacuation and shelter-in-place plans:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan for large scale (multiple healthcare organizations and multiple local jurisdictions/regions) evacuation and sheltering-in-place operations. Plans should include but are not limited to the following elements:

- Coordination of healthcare organization plans with the local and state evacuation plans
- Identification and coordination of the roles and responsibilities of each partner healthcare organization, their activation procedures, communication plans, and resource sharing/request plans for evacuation
- Identification of the evacuation resources that are available to the healthcare organizations (For supporting information, see Capability 1 — Healthcare Preparedness)
- Processes to request resources (For supporting information, please see Capability 3 — Emergency Operations Coordination)
- Regional resource support (from Healthcare Coalition) to healthcare organizations undergoing evacuation and shelter-in-place operations (if requested and available)
- Strategies that assist healthcare organizations return to their facilities after evacuation including but not limited to (For further information, please see Capability 2 — Healthcare System Recovery):
    - Resource assistance (if requested and available)

    - Assistance with resource reconstitution if available
    - Assistance with reimbursement processes
- Coordination of information between the healthcare organizations and appropriate state/local early warning agencies on the advisability of shelter-in-place or evacuation operations
- State coordination of processes to keep communication and resource request processes open, efficient, and redundant during shelter-in-place operations
- State coordination with interstate Emergency Management Assistance Compact requests (EMAC) and Federal (DHHS Regional Emergency Coordinators) for assistance
- State coordination with Federal Coordinating Centers (FCC) and National Disaster Medical System (e.g., coordination with FCC to establish patient movement protocols between the private sector and the Federal patient movement system)

Note: Evacuation plans are required by The Joint Commission standards for Hospitals, Critical Access Hospitals, LTC, Home Care, Ambulatory Care, Behavioral Health Care, Labs EM.02.01.01 EP 2

P2: (*Required*) Healthcare organization preparedness to receive evacuation surge:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop a plan for receiving a large scale (multiple healthcare organizations and multiple local jurisdictions/regions) evacuation in other regions of the state or other states. This plan should include strategies to coordinate evacuation plans with the appropriate healthcare organizations that are most likely to receive the patients of an evacuation. The plan should also include processes to assist these healthcare organizations with resources if requested and available.

P3: (*Required*) Transportation options for evacuation:

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain patient transport processes for evacuation. The coordination of multiple transport options include but are not limited to following considerations:

- Air, ground, and sea options
- Public and private options
- National guard collaboration
- Federal Coordinating Centers (FCC) and National Disaster Medical System collaboration (e.g., coordination with FCC to establish patient

movement protocols between the private sector and the Federal patient movement system)

- Volunteer agencies
- Family members
- Additional innovative options (just-in-time options)

Transportation processes should be consistent with applicable laws, regulations, and policies:

- Emergency Medical Treatment and Active Labor Act (EMTALA) and
- The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

E1: (*Based on priorities and needs*) Specialized equipment needed to evacuate patients:

The State and Healthcare Coalitions, in coordination with healthcare organizations, assess the need for a local or regional cache of evacuation equipment for use by healthcare organizations to assist with evacuation or shelter-in-place operations (e.g., evacuation chairs, transport ventilators). This type of equipment should include a process to request the resources and operational guidelines.

Capability 14: Responder Safety and Health

Definition: The responder safety and health capability describes the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This includes processes to equip, train, and provide other resources needed to ensure healthcare workers at the highest risk for adverse exposure, illness, and injury are adequately protected from all hazards during response and recovery operations.

Associated Performance Measures:

- HPP Specific Measure #10: **Percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions and to protect all** of the coalition **member employees (including healthcare and non-healthcare employees)**
    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation to see data elements and other guidance associated with this measure.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers

Required Resource Elements:

P1: (*Required*) Pharmaceutical needs assessment:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and other stakeholders (e.g., Schools of Pharmacy, State Boards of Pharmacy, pharmacy organizations, and academia) perform a needs assessment to determine the types of pharmaceuticals that may be needed in an area to protect healthcare workers from priority threats. This includes an assessment of the threats, vulnerabilities, and consequences of a CBRNE exposure to provide risk informed medical measures and ensures healthcare responders are protected. Hazard identification is performed to provide guidance when developing strategies to store, rotate, replace, and distribute pharmaceuticals at the local or regional level and/or healthcare organization specific level.

P2: (*Based on priorities and needs*) Pharmaceutical cache storage, rotation, replacement, and distribution:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and other stakeholders (e.g., Schools of Pharmacy, State Boards of Pharmacy, pharmacy organizations, and academia) develop, refine, and/or maintain pharmaceutical caches. Caches of pharmaceuticals should include an operational plan that includes but is not limited to the following elements:

- Pharmacy oversight (agreements with pharmaceutical agencies addressing storage, rotation and replacement procedures or modalities)
- Placement of caches in strategic locations
- Emergency contact information for personnel with access to the cache
- Processes for the timely access to the cache for identified healthcare organizations
- A contingency access plan
- Procedures and agreements for distribution
- Coordination with emergency management, private transport agencies, security agencies and/or public safety to address:
    - Security measures for the integrity of the supply chain
    - Supply chain management during an incident
- Maintenance and rotation schedules
    - Storage in appropriate conditions to maximize pharmaceutical shelf life

- Protocols to rotate pharmaceutical stock and/or processes for return management of stock
- Handling and administration protocols for each type of pharmaceutical in the stock such as:
    - Antibiotic drugs for prophylaxis and post-exposure prophylaxis to biological agents
    - Nerve agent antidotes
    - Antiviral drugs
    - Medications needed for exposure to other threats (e.g., radiological events)
    - Coordination of planning to address options or the need for additional pharmaceuticals for healthcare workers families

P3: (*Required*) Medical Countermeasure dispensing:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and other stakeholders, develop, refine, and sustain a plan to provide medical countermeasures to treat or provide prophylaxis to the affected healthcare worker population in accordance with public health guidelines and/or recommendations. This includes healthcare coordination with Federal countermeasure programs such as the Strategic National Stockpile program and other relevant programs.

E1: (*Based on priorities and needs*) Pharmaceutical cache protection:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health and other stakeholders, assesses the need for additional pharmaceutical caches to include the appropriate security and environmental protection systems that protect medical supplies and pharmaceuticals. This type of equipment should include but is not limited to:

- Appropriate security for the pharmaceutical caches and medical supplies
- Appropriate environmental storage devices to maintain the appropriate climate control for the caches
- Operational plans to maintain the caches

S1: (*Based on priorities and needs*) Pharmaceutical cache training:

The stockpiling of pharmaceutical caches in any location should include plans for associated training. Training curriculums may include information regarding how to access the cache such as where it is located, request processes and contact information. Training for healthcare organizations should include the coordination of just-in-time training (e.g., how it works, when and how to administer, and precautions and follow-up).

Function 2: Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during response

Required Resource Elements:

P1: (*Required*) Personal protective equipment needs assessment:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and other relevant stakeholders, perform a needs assessment to determine additional levels and types of PPE to protect healthcare workers based on the risk assessments, casualty estimates, level of decontamination expected, and isolation or quarantine planned in the affected areas.

P2: (*Based on priorities and needs*) Personal protective equipment caches:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and other relevant stakeholders, assess the need for additional caches of PPE based on estimated resource needs. This should include but is not limited to the following elements:

- Coordination across a region so that training programs are consistent and pertain to the equipment that will be used
- Placement of PPE caches in strategic locations based on where the cache will be most effective
- Storage in appropriate conditions to maximize shelf life
- Protocols to rotate stock as needed
- Protocols for return management of stock as needed
- Instructions for use of all PPE in the cache
- Cache inventory that is consistent with local brands used by healthcare organizations (e.g., precludes the need for fit testing for N95 during disaster situations)

P3: (*Required*) Personal protective equipment supply and dispensing:

The State, in coordination with healthcare organizations, Healthcare Coalition, emergency management, public health, and other relevant stakeholders develop, refine, and sustain a plan to assist healthcare organization with PPE when requested and available. These processes should include but is not limited to the following elements:

- Processes to assist healthcare organizations implement emergency supply plans or activate MOUs with vendors that can supply PPE resource support (e.g., private vendor support)
- Processes to access a local or regional cache if available

- Processes to request PPE from local or state incident management
- Processes to resupply local and regional caches of PPE

E1: (*Based on priorities and needs*) Personal Protective Equipment for healthcare workers:

Have or have access to PPE consistent with the identified risks of the local jurisdiction and the PPE needs of response personnel across varying job functions. The type of PPE that is procured for local or regional caches should be consistent with the type of PPE used locally to promote interoperability and inter-facility sharing. Equipment should meet applicable nationally recognized standards as defined by the OSHA, CDC, FDA, and or Interagency Board for Equipment Standardization and Interoperability (https://iab.gov).

S1: (*Based on priorities and needs*) Personal protective equipment training: The State, in coordination with healthcare organizations, Healthcare Coalition, emergency management, public health, and other relevant stakeholders, develop, refine, and sustain processes to provide coordinated training to healthcare organizations when additional PPE caches are developed. The training for the use of supplemental caches of PPE should include coordination with healthcare organization specific training programs, and compliance with Federal or state OSHA regulations.

Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with the medical preparedness and response to incidents and events.

Associated Performance Measures:

- HPP-PHEP Measure #11: Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe

- **HPP Specific Measure #12: Percent of healthcare coalitions (HCCs) that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident.**

    - **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Please go to http://www.phe.gov/preparedness/planning/evaluation
to see data elements and other guidance associated with this measure.

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Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations

Required Resource Elements:

P1: (*Required*) Volunteer needs assessment for healthcare organizations response:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and the appropriate volunteer organizations, perform a volunteer needs assessment. The volunteer needs assessment should include but is not limited to the following elements:

- Identification of situations that would necessitate the need for volunteers in healthcare organizations
- Estimation of the anticipated number of volunteers based on identified situations and resource needs of healthcare organizations
- Identification of the health professional roles that may be needed by healthcare organizations in these situations
- Identification of the volunteer liability issues and scope of practice issues that may deter volunteer use by healthcare organizations

P2: (*Required*) Collect, assemble, maintain and utilize volunteer information:

The State coordinates with healthcare organizations to develop volunteer management guidelines to facilitate the use of volunteers to support specific healthcare roles. These guidelines should ensure following aspects of volunteer management can be achieved:

- Information must be controlled and managed by authorized personnel responsible for the data
- Volunteer information is collected, assembled, maintained, and utilized in a manner consistent with Federal, state, and local laws governing information security and confidentiality
- Credentials and qualifications of health professionals are collected, registered, and verified with the issuing entity or appropriate authority
- Credentials and qualifications of professions consistent with current guidance from the HHS ESAR-VHP program are registered, collected, and verified
- Volunteers are assigned to credential levels consistent with current guidance from the HHS ESAR-VHP program. Assignments are based on the credentials and qualifications that the State has collected and verified with the issuing entity or appropriate authority

- Volunteer health professional/emergency preparedness affiliations are recorded (individual, including local, state, and Federal entities)
- Volunteers willing to participate in a federally coordinated emergency response are identified
- Volunteer recruitment and retention strategies are implemented

E1: (*Required*) Electronic volunteer registration system:

Have or have access to an electronic registration system for recording and managing volunteer information that is compliant with the current guidelines of the HHS ESAR-VHP program.

Suggested resource:

- Emergency System for Advance Registration of Volunteer Health Professionals: http://www.phe.gov/esarvhp/pages/about.aspx

Function 2: Volunteer notification for healthcare response needs

Required Resource Elements:

P1: (*Required*) Process to contact registered volunteers:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate volunteer organizations, develop a process with the applicable lead jurisdictional agency to contact registered volunteers and identify those willing and available to participate in the healthcare response operation.

P2: (*Required*) Process to confirm credentials of responding volunteers:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate volunteer organizations, develop a process to confirm credentials of responding volunteers that have been requested for healthcare organizations.

P3: (*Required*) Volunteer request process:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate volunteer agencies, identify the processes to request volunteers that are to be utilized in healthcare organizations.

Function 3: Organization and assignment of volunteers

Required Resource Elements:

P1: (*Required*) Volunteer deployment protocols:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate local volunteer organizations, develops a plan to assist healthcare organizations with the deployment management of volunteers during a response. This coordinated planning should include but is not limited to the following elements:

- Protocols for deploying and tracking public health professional roles
- Protocols for maintaining a history of volunteer deployments
- Protocols for maintaining the security of volunteers' personal information provided from another jurisdiction
- Protocols for returning or destroying information no longer needed

P2: (*Required*) Briefing template for healthcare volunteers:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate local volunteer organizations, coordinate for the use of a template that can be provided to healthcare organizations for briefing volunteers on the current incident conditions and response operations. The template should include but is not limited to the following elements:

- Instructions on the current status of the emergency
- Volunteer health professional role
- Just-in-time training
- Safety instructions
- Any applicable liability risks related to the incident and the volunteers' roles, psychological first aid, and/or volunteer stress management

P3: (*Required*) Volunteer support services:

The State, in coordination with healthcare organizations, Healthcare Coalitions, emergency management, public health, and the volunteer organizations, develop a process to coordinate with emergency management or other jurisdictional lead agencies to ensure response requirements (e.g., housing, feeding and mental/behavioral health needs) for healthcare volunteers are supported.

Function 4: Coordinate the demobilization of volunteers

Required Resource Elements:

P1: (*Required*) Volunteer release processes:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate local volunteer organizations, coordinate the processes for releasing volunteers from healthcare organizations. This coordination should include but is not limited to the following:

- Demobilization of volunteers in accordance with protocols for demobilization from the appropriate level of incident management
- Ensure the assigned tasks are completed, and/or replacement volunteers are informed of the task status
- Determination of whether additional volunteer assistance is needed
- Ensure equipment is returned by volunteers
- Confirmation of the volunteer's follow-up contact information

P2: (*Required*) Volunteer exit screening protocols:

The State, in coordination with healthcare organizations, Healthcare Coalitions, public health, and the appropriate local volunteer organizations, develop a process to ensure volunteers provide accurate and complete information during out-processing. Documentation should include but is not limited to the following:

- Identification of injuries and illnesses acquired during the response
- Identification of mental/behavioral health needs due to participation in the response
- When requested or indicated, referral of volunteers to medical and mental/behavioral health services

The full *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* is available at:

http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.

Appendix 5
At-a-Glance Summary of the Public Health Preparedness Capabilities: National Standards for State and Local Planning

The purpose of the 2012-2017 HPP-PHEP cooperative agreement programs is to provide technical assistance and resources that support state, local, territorial, and tribal public health departments and healthcare systems/organizations in demonstrating measurable and sustainable progress toward achieving public health and healthcare preparedness capabilities that promote prepared and resilient communities.

The public health and healthcare preparedness capabilities are designed to help state and local health departments with their strategic planning. Released in March 2011, CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* establishes national standards for public health preparedness capabilities-based planning that assists state and local planners in identifying gaps in preparedness, determining the specific jurisdictional priorities, and developing plans for building and sustaining public health capabilities.

Public Health Preparedness Capabilities: National Standards for State and Local Planning is available at http://www.cdc.gov/phpr/capabilities/. Below is an at-a-glance summary of the capability definitions, functions, and priority resource elements.

Capability 1: Community Preparedness
Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:

- Support the development of public health, medical and mental/behavioral health systems that support recovery
- Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals
- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community
- Identify those populations that may be at higher risk for adverse health outcomes
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane)

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Determine risks to the health of the jurisdiction

Priority Resource Elements:

P1: *(Priority)* Written plans should include policies and procedures to identify populations with the following:

- Health vulnerabilities such as poor health status
- Limited access to neighborhood health resources (e.g., disabled, elderly, pregnant women and infants, individuals with other acute medical conditions, individuals with chronic diseases, underinsured persons, persons without health insurance)
- Reduced ability to hear, speak, understand, or remember
- Reduced ability to move or walk independently or respond quickly to directions during an emergency
- Populations with health vulnerabilities that may be caused or exacerbated by chemical, biological, or radiological exposure

These procedures and plans should include the identification of these groups through the following elements:

- Review/access to existing health department data sets
- Existing chronic disease programs/maternal child health programs, community profiles
- Utilizing the efforts of the jurisdiction strategic advisory council
- Community coalitions to assist in determining the community's risks

P2: *(Priority)* Written plans should include a jurisdictional risk assessment, utilizing an all-hazards approach with the input and assistance of the following elements:

- Public health and non–public health subject matter experts (e.g., emergency management, state radiation control programs/radiological subject matter experts [http://www.crcpd.org/Map/RCPmap.htm])
- Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities

This jurisdictional risk assessment should identify the following elements:

- Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/behavioral health systems
- The relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services
- The impact of those risks on public health, medical, and mental/behavioral health infrastructure

Jurisdictional risk assessment must include at a minimum the following elements:

- A definition of risk
- Use of Geospatial Informational System or other mechanism to map locations of at-risk populations
- Evidence of community involvement in determining areas for risk assessment or hazard mitigation

- Assessment of potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure

Function 2: Build community partnerships to support health preparedness

Priority Resource Elements:

P1: *(Priority)* Written plans should include a policy and process to participate in existing (e.g., led by emergency management) or new partnerships representing at least the following 11 community sectors: business; community leadership; cultural and faith-based groups and organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; state office of aging or its equivalent; education and childcare settings.

P2: *(Priority)* Written plans should include a protocol to encourage or promote medical personnel (e.g., physicians, nurses, allied health professionals) from community and faith-based organizations and professional organizations to register and participate with community Medical Reserve Corps or state Emergency Systems for Advance Registration of Volunteer Health Professionals programs to support health services during and after an incident. *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Function 3: Engage with community organizations to foster public health, medical and mental/behavioral health social networks

Function 4: Coordinate training or guidance to ensure community engagement in preparedness efforts

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation that public health has participated in jurisdictional approaches to address how children's medical and mental/behavioral healthcare will be addressed in all-hazard situations, including but not limited to the following elements:

- Approaches to support family reunification
- Care for children whose caregivers may be killed, ill, injured, missing, quarantined, or otherwise incapacitated for lengthy periods of time
- Increasing parents' and caregivers' coping skills
- Supporting positive mental/behavioral health outcomes in children affected by the incident
- Providing the opportunity to understand the incident

P2: *(Priority)* Written plans should include a process and procedures to build and sustain volunteer opportunities for residents to participate with local emergency responders and community safety efforts year round (e.g., Medical Reserve Corps). *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Capability 2: Community Recovery

Definition: Community recovery is the ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan

and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible.

This capability supports National Health Security Strategy Objective 8: Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical and mental/behavioral health services and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Identify and monitor public health, medical and mental/behavioral health system recovery needs

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes for collaborating with community organizations, emergency management, and healthcare organizations to identify the public health, medical, and mental/behavioral health system recovery needs for the jurisdiction's identified hazards.

P2: *(Priority)* Written plans should include how the health agency and other partners will conduct a community assessment and follow-up monitoring of public health, medical, and mental/behavioral health system needs after an incident.
(For additional or supporting detail, see Capability 1: Community Preparedness)

P3: *(Priority)* Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan):

- Definitions and identification of essential services needed to sustain agency mission and operations
- Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)
- Scalable work force reduction
- Limited access to facilities (social distancing, staffing or security concerns)
- Broad-based implementation of social distancing policies if indicated
- Positions, skills and personnel needed to continue essential services and functions (Human Capital Management)
- Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident
- Alternate worksites
- Devolution of uninterruptible services for scaled down operations
- Reconstitution of uninterruptible services

Function 2: Coordinate community public health, medical and mental/behavioral health system recovery operations

Function 3: Implement corrective actions to mitigate damages from future incidents

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

Functions: This capability consists of the ability to perform the functions listed below.
Function 1: Conduct preliminary assessment to determine need for public activation

Function 2: Activate public health emergency operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include standard operating procedures that provide guidance for the management, operation, and staffing of the public health emergency operations center or public health functions within another emergency operations center. The following should be considered for inclusion in the standard operating procedures:

- Activation procedures and levels, including who is authorized to activate the plan and under what circumstances
- Notification procedures; procedures recalling and/or assembling required incident command/management personnel and for ensuring facilities are available and operationally ready for assembled staff

S1: *(Priority)* Staff involved in incident response should have competency in the incident command and emergency management responsibilities they may be called upon to fulfill in an emergency. A precursor to having competency is for staff to attain the applicable National Incident Management System (NIMS) Certification based on discipline, level and/or jurisdictional requirements. Additional information on NIMS is located at http://www.fema.gov/emergency/nims/.

A suggested approach to establish your NIMS training needs based on CDC guidelines is outlined below.

Tier One: Personnel who, in the event of a public health emergency, will not be working within the emergency operations center/multiagency coordination system or will not be sent out to the field as responders. Applicable training courses are

- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Tier Two: Personnel who, in a public health emergency, will be assigned to fill one of the functional seats in the emergency operations center during the response operation. Applicable training courses are listed below:

- Introduction to Incident Command System (IS-100.b)

- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- National Incident Management System: An Introduction (IS-700a)
- National Response Framework: An Introduction (IS-800.b)

Tier Three: Personnel who, in a public health emergency, have the potential to be deployed to the field to participate in the response, including personnel who are already assigned to a field location. Applicable training courses are listed below:

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Intermediate Incident Command System (ICS-300)
- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Tier Four: Personnel who, in a public health emergency, are activated to Incident Management System leadership and liaison roles and are deployed to the field in leadership positions. Applicable training courses are listed below

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Intermediate Incident Command System (ICS-300)
- Advanced Incident Command System (ICS-400)
- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Function 3: Develop incident response strategy

Priority Resource Element:

P1: *(Priority)* Written plans should include a template for producing Incident Action Plans. The following should be considered for inclusion in Incident Action Plans as indicated by the scale of the incident:

- Incident goals
- Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)
- Response strategies (priorities and the general approach to accomplish the objectives)
- Response tactics (methods developed by Operations to achieve the objectives)
- Organization list with Incident Command System chart showing primary roles and relationships
- Assignment list with specific tasks
- Critical situation updates and assessments
- Composite resource status updates
- Health and safety plan (to prevent responder injury or illness)
- Logistics plan (e.g., procedures to support Operations with equipment and

supplies)
- Responder medical plan (providing direction for care to responders)
- Map of the incident or of ill/injured persons (e.g., map of incident scene)
- Additional component plans, as indicated by the incident

The use of the following Incident Command System forms or equivalent documentation is recommended: Form 202 – "Incident Objectives," Form 203 – "Organization Assignment List," and Form 204 – "Division/Group Assignment List."

Function 4: Manage and sustain the public health response

Priority Resource Element:

P1: *(Priority)* Written plans should include processes and protocols to ensure the continued performance of pre-identified essential functions during a public health incident and during an incident that renders the primary location where the functions are performed inoperable. This can be a stand-alone plan or annex but at a minimum the plan must include these elements:

- Definitions and identification of essential services needed to sustain agency mission and operations
- Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)
- Scalable workforce reduction
- Limited access to facilities (e.g., social distancing and staffing or security concerns)
- Broad-based implementation of social distancing policies if indicated
- Positions, skills, and personnel needed to continue essential services and functions (Human Capital Management)
- Identification of agency vital records (e.g., legal documents, payroll, and staff assignments) that support essential functions and/or that must be preserved in an incident
- Alternate worksites
- Devolution of uninterruptible services for scaled-down operations
- Reconstitution of uninterruptible services

For guidance on developing a Continuity of Operations Plan, refer to the resources provided by the Federal Emergency Management Agency: http://www.fema.gov/government/coop/index.shtm

Function 5: Demobilize and evaluate public health emergency operations

Priority Resource Element:

P1: *(Priority)* Written plans should include demobilization procedures for public health operations. The following should be considered for inclusion:

- General information about the demobilization process
- Responsibilities/agreements for reconditioning of equipment/resources
- Responsibilities for implementation of the Demobilization Plan
- General release priorities (i.e., resource type such as staff or equipment to be released) and detailed steps and processes for releasing those resources
- Directories (e.g., maps and telephone listings)

The use of Incident Command System Form 221 - "Demobilization Checkout" or equivalent documentation is recommended.

Capability 4: Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Activate the emergency public information system

Priority Resource Elements:

P1: *(Priority)* Written plans should include description of the roles and responsibilities for the Public Information Officer, support staff (depending on incident and subject matter expertise), and potential spokesperson(s) to convey information to the public.

P2: *(Priority)* Written plans should include message templates that address jurisdictional vulnerabilities, should be maintained on a jurisdictionally defined regular basis, and include the following elements:

- Stakeholder identification
- Potential stakeholder questions and concerns
- Common sets of underlying concerns
- Key messages in response to the generated list of underlying stakeholder questions and concerns

S1: *(Priority)* Public Information staff should complete the following National Incident Management System training:

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Emergency Support Function 15 External Affairs: A New Approach to Emergency Communication and Information Distribution (IS-250)
- National Incident Management System, An Introduction (IS-700.a)
- National Incident Management System Public Information Systems (IS-702.a)
- National Response Framework, An Introduction (IS-800.b)

S2: *(Priority)* Deliver key messages using principles of crisis and emergency risk communication. To ensure this, the following training must be taken within six months of hire date and at least once every five years thereafter by public information staff within the jurisdiction:

- CDC Crisis and Emergency Risk Communication Basic
- CDC Crisis and Emergency Risk Communication for Pandemic Influenza

These courses may be taken in any of the following ways:

- Self-paced online training, which is available at all times
- Any CDC webinar course, which is offered four times per year
- In-person training at CDC, which is offered four times per year
- Access to Crisis and Emergency Risk Communication courses at the

If for any reason staff is not able to attend these courses, completing training given by staff that has been CDC trained is acceptable (train the trainer model).

Function 2: Determine the need for a joint public information system

Priority Resource Element:

E1: *(Priority)* Minimum components of a Virtual Joint Information Center:

- Equipment to exchange information electronically within the jurisdiction and CDC, in real-time, if possible
- Shared site or mechanism or system to store electronic files of joint information center products, e-mail group lists, incident information, and scheduling

  Minimum components of a Virtual Joint Information Center for territory jurisdictions entail the following:
- Electronic access to both the CDC public website and the World Health Organization shared information site

Function 3: Establish and participate in information system operations

Function 4: Establish avenues for public interaction and information exchange

Function 5: Issue public information, alerts, warnings, and notifications

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Determine role for public health in fatality management

Priority Resource Element:

P1: *(Priority)* Written plans should include memoranda of agreement, memoranda of understanding, mutual aid agreements, contracts, and/or letters of agreement with other agencies to support coordinated activities and with other jurisdictions to share resources, facilities, services, and other potential support required during the management of fatalities. Requests should be determined by the local authority and follow the jurisdictional escalation process (i.e., local to state to federal).

- State and federal resources (to include Disaster Mortuary Operational Response Teams) are requested when anticipated resource needs exceed the local capacity. County/jurisdictional plans should address mass fatality planning and thresholds for requesting additional resources.
- Federal resources should be engaged/notified through the U.S. Department

of Health and Human Services (HHS) Regional Emergency Coordinators
- Resources available through mutual aid (e.g., Emergency Management Assistance Compact (EMAC), memoranda of understanding, and/or memoranda of agreement) should be engaged/notified through appropriate channels (EMAC Coordinator, emergency management)

Function 2: Activate public health fatality management operations

Function 3: Assist in the collection and dissemination of antemortem data

Priority Resource Element:

P1: *(Priority)* Written plans should include a procedure for the collection of antemortem data. Consideration should be given to the inclusion of these elements:

- Data collection/dissemination methods
  - □ Call Center or 1-800 number
  - □ Family Reception Center
  - □ Family Assistance Center
- Staff who can perform the following functions:
  - □ Administrative activities
  - □ Interviews of families in order to acquire antemortem data
  - □ System data entry of antemortem data

Function 4: Participate in survivor mental/behavioral health services

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols developed in conjunction with jurisdictional mental/behavioral health partners to identify services to provide to survivors after an incident involving fatalities. Written plans should include a contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the incident. Consideration should be given to the inclusion of the following elements:

- Mental/behavioral health professionals
- Spiritual care providers
- Hospices
- Translators
- Embassy and Consulate representatives when international victims are involved

P2: *(Priority)* Written plans should include list of staff selected in advance of an incident that could potentially fill the fatality management roles adequate to a given response.

Function 5: Participate in fatality processing and storage operations

Priority Resource Element:

P1: *(Priority)* Written plans should include protocols that ensure that the health department, through healthcare coalitions or other mechanisms, supports the coordination of healthcare organization fatality management plans with the

jurisdictional fatality management plan.

Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Identify stakeholders to be incorporated into information flow

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes to engage stakeholders that may include the following:

- Law enforcement
- Fire
- Emergency Medical Services
- Private healthcare organizations (e.g., hospitals, clinics, large corporate medical provider organizations and urgent care centers)
- Fusion centers
- For states: local health departments, tribes and territories
- Individuals who have or may need a security clearance, based on functional role

P2: *(Priority)* Written plans should include a role-based public health directory that will be used for public health alert messaging. The directory profile of each user includes the following elements:

- Assigned roles
- Multiple device contact information
- Organizational affiliation

Function 2: Identify and develop rules and data elements for sharing

Priority Resource Elements:

P1: *(Priority)* Written plans should include a listing of data-exchange requirements for each stakeholder (including the use of common terminology, definitions, and lexicon by all stakeholders) that adhere to available national standards for data elements to be sent and data elements to be received.

P2: *(Priority)* Written plans should include health information exchange protocols for each stakeholder that identify determinants for exchange and which may include the following elements:

- Unusual cluster(s) or illness that threaten closure of institutional settings (e.g., illness among healthcare workers or prisoners)
- High burden of illness or a cluster of illness confined to a specific population (e.g., racial or ethnic group, or vulnerable populations)

- Illness burden that is expected to overwhelm local medical or public health resources
- A public health laboratory finding of interest (e.g., a novel virus identified by lab) that is not picked up clinically or through other surveillance
- Large numbers of patients with similar and unusual symptoms
- Large number of unexplained deaths
- Higher than expected morbidity and mortality associated with common symptoms and/or failure of patients to respond to traditional therapy
- Simultaneous clusters of similar illness in noncontiguous areas
- Received threats or intelligence
- Incidents in other jurisdictions that raise possible risk in home jurisdiction (e.g., elevation of pandemic influenza alert level)

Function 3: Exchange information to determine a common operating picture

Priority Resource Elements:

P1: *(Priority)* Written plans should include a protocol for the development of public health alert messages that include the following elements:

- Time sensitivity of the information
- Relevance to public health
- Target audience
- Security level or sensitivity
- The need for action may include
    - □ Awareness
    - □ Request a response back
    - □ Request that specific actions be taken

Capability 7: Mass Care

Definition: Mass care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Determine public health role in mass care operations

Function 2: Determine mass care needs of the impacted population

Priority Resource Elements:

P1: *(Priority)* Written plans should include an assessment form to be used in shelter environmental health inspections, including at a minimum the following elements:

- Identification of barriers for disabled individuals
- Structural integrity
- Facility contamination (e.g., radiological, nuclear, or chemical)
- Adequate sanitation (e.g., toilets, showers, and hand washing stations) and waste removal
- Potable water supply

- Adequate ventilation
- Clean and appropriate location for food preparation and storage

P2: *(Priority)* Written plans should include a list of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as congregate locations (based on the size, scope, and nature of potential incidents and jurisdictional risk assessment).

E1: *(Priority)* Have or have access to a tool for health screening of individuals during shelter registration. The following are suggested elements for inclusion:

- Immediate medical needs
- Assistive device needs
- Mental health needs
- Sensory impairment or other disability
- Medication use
- Need for assistance with activities of daily living
- Substance abuse

Function 3: Coordinate public health, medical, and mental/behavioral health services

Priority Resource Elements:

P1: *(Priority)* Written plans should include memoranda of understanding, memoranda of agreement, or letters of agreement with medication providers, including but not limited to the following elements:

- Requesting medication from providers
- Bringing medication to congregate locations
- Storing and distributing medication at congregate locations
- Referring and transporting individuals to pharmacies and other providers for medication

(For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing, Capability 9: Medical Materiel Management and Distribution, and Capability 10: Medical Surge)

P2: *(Priority)* Written plans should include a scalable congregate location staffing model based on number of individuals, resources available, competing priorities, and time frame in which intervention should occur that is incident-driven and, at a minimum, includes the ability to provide the following elements:

- Medical care services
- Management of mental/behavioral disorders
- Environmental health assessments (e.g., food, water, and sanitation)
- Data collection, monitoring, and analysis
- Infection control practices and procedures

P3: *(Priority)* Written plans should include procedures to coordinate with partner agencies to transfer individuals from general shelters to specialized shelters or medical facilities if needed, including the following procedural elements:

- Patient information transfer (e.g., current condition and medical equipment needs)
- Physical transfer of patient

(For additional or supporting detail, see Capability 10: Medical Surge)

P4: *(Priority) Written* plans should include a process to coordinate with partner agencies to monitor populations at congregate locations, including but not limited to the following processes:

- Establishing registries for exposed or potentially exposed individuals for long-term health monitoring
- Separate shelter facilities for monitoring individuals at congregate locations
- Identifying, stabilizing and referring individuals who need immediate medical care or decontamination
- Prioritization of at-risk populations at congregate locations that have specific needs after a radiation incident (e.g., children, elderly, and pregnant women)

P5: *(Priority)* Written plans should include a scalable congregate location staffing matrix identifying at least one back-up for each population monitoring and decontamination response role. Skill sets at a minimum should include the following elements:

- The ability to manage population monitoring operation
- The ability to monitor arrivals for external contamination and assess exposure
- The ability to assist with decontamination services
- The ability to assess exposure and internal contamination

Function 4: Monitor mass care population health

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process to conduct ongoing shelter population health surveillance, including the following elements:

- Identification or development of mass care surveillance forms and processes
- Determination of thresholds for when to start surveillance
- Coordination of health surveillance plan with partner agencies' (e.g., Red Cross) activities

(For additional or supporting detail, see Capability 14: Public Health Surveillance and Epidemiological Investigation)

P2: *(Priority)* Written plans should include templates for disaster-surveillance forms, including Active Surveillance and Facility 24-hour Report forms.

Capability 8: Medical Countermeasure Dispensing

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Identify and initiate medical countermeasure dispensing strategies

Priority Resource Elements:

P1: *(Priority)* Written plans should include standard operating procedures that provide

guidance to identify the medical countermeasures required for the incident or potential incident. Consideration should be given to the following elements:

- Number and location of people affected by the incident, including a process to collect and analyze medical and social demographic information of the jurisdiction's population to plan for the types of medications, durable medical equipment, or consumable medical supplies that may need to be provided during an incident, including supplies needed for the functional needs of at-risk individuals.
- Agent or cause of the incident
  (For additional or supporting detail, see Capability 12: Public Health Laboratory Testing)
- Severity of the incident
- Potential medical countermeasures
  (For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)
- Time line for establishing medical countermeasure dispensing operations
- Personnel and staffing mix

Function 2: Receive medical countermeasures

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols to request additional medical countermeasures, including memoranda of understanding or other letters of agreement with state/local partners. Consideration should be given to the following elements:

- Assessment of local inventory/medical countermeasure caches
- Identification of local pharmaceutical and medical-supply wholesalers
- Identification of a decision matrix guiding the process of requesting additional medical countermeasures if local supplies are exhausted. Matrix should take into account the Stafford Act and U.S. Department of Health and Human Services Regional Emergency Coordinators.
- If jurisdictions decide to purchase their own medical countermeasures, they are required to meet regulatory standards (abide by U.S. Food and Drug Administration standards including current good manufacturing practices, have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation)

Function 3: Activate dispensing modalities

Priority Resource Elements:

P1: *(Priority)* Written plans should include written agreements (e.g., memoranda of agreement, memoranda of understanding, mutual aid agreements or other letters of agreement) to share resources, facilities, services, and other potential support required during the medical countermeasure dispensing activities.

P2: *(Priority)* Written plans should include processes and protocols to govern the activation of dispensing modalities.

- Identify multiple dispensing modalities that would be activated depending

on the incident characteristics (e.g., identified population and type of agent/exposure). Consideration should be given to the following elements:

- □ Traditional public health operated (e.g., open points of dispensing)
- □ Private organizations (e.g., closed points of dispensing)
- □ Pharmacies
- □ Provider offices and clinics
- □ Military/tribal
- □ Incarcerated population
- □ Other jurisdictionally approved dispensing modalities

– Initiate notification protocols with the dispensing locations. The following information should be determined for the sites:

- □ Dispensing site name/identifier
- □ Demand estimate (number of people planning to visit the site)
- □ Required throughput
- □ Staff required to operate one shift
- □ Number of shifts of distinct staff
- □ Staff availability
- □ Total number of staff required to operate the dispensing location through the whole incident

– Plan for functional needs of at-risk individuals (e.g., wheelchair access for handicapped)

– Identify, assess, prioritize, and communicate legal and liability dispensing barriers to those with the authority to address issues. Consideration should be given to the following elements:

- □ Clinical standards of care
- □ Licensing
- □ Civil liability for volunteers
- □ Liability for private sector participants
- □ Property needed for dispensing medication

Function 4: Dispense medical countermeasures to identified population

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to govern the dispensing of medical countermeasures to the target population.

– Protocol for screening and triaging patients, taking into consideration an assessment of patient characteristics (e.g., age, weight, clinical manifestations, available medical history, and drug or food allergies, assessment of radiation exposure duration and time since exposure, presence of radioactive contamination on the body or clothing, intake of radioactive materials into the body, identification of the radioactive isotope, removal of external or internal contamination) to determine the medical countermeasure to dispense

– Ensure that the permanent medical record (or log/file) of the recipient indicates the following information as deemed necessary:

- □ The date the medical countermeasure was dispensed

□ Information on the medical countermeasure including, but not limited to, product name, national drug control number, and lot number
□ The name and address of the person dispensing the medical countermeasure. Federal dispensing law requires: name/address of dispenser, prescription number, date of prescription, name of prescriber, name of patient (if stated on prescription), directions for use, and cautionary statements.
□ The edition date of the information statement (e.g., pre-printed drug information sheets) distributed

– Ensure medical countermeasure recipient receives the information sheet matching the medical countermeasure dispensed
– Data recording protocols to report the data at an aggregate level to state/federal entities. Considerations should be given to population demographics (e.g., sex, age group, and if an at-risk individual) and dispensing information (e.g., medical countermeasure name, location, and date)

Function 5: Report adverse events

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to govern reporting of adverse events. The following items should be considered in the plans:

– Guidance and communications messages/campaign that articulates the importance of adverse reporting regardless of suspected cause
– Process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed and how to report adverse events
– Triage protocols when receiving notifications of adverse events
– Protocols when receiving notifications of adverse events. Information required to document adverse events includes the following:
□ Patient, provider, and reporter demographics
□ Adverse event
□ Relevant diagnostic tests/laboratory data
□ Recovery status
□ Vaccine(s)/pharmaceutical(s) received, including receipt location, date, vaccine/pharmaceutical type, lot number, and dose number
– Utilize existing federal and jurisdictional adverse event reporting system, processes and protocols

S1: *(Priority)* Public Health staff should be trained on federal as well as their jurisdiction's adverse event reporting system, processes and protocols.

Capability 9: Medical Materiel Management and Distribution

Definition: Medical materiel management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and

track medical materiel (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical materiel, as necessary, after an incident.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Direct and activate medical materiel management and distribution

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of primary and backup receiving sites that take into consideration federal Strategic National Stockpile recommendations. Written plans should include the following elements:

- Type of site (commercial vs. government)
- Physical location of site
- 24-hour contact number
- Hours of operation
- Inventory of material-handling equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
- Inventory of office equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
- Inventory of storage equipment (e.g., refrigerators and freezers) on-site and list of minimum materials/supplies that need to be procured and/or delivered at the time of the incident

P2: *(Priority)* Written plans should include transportation strategy. If public health will be transporting material using their own vehicles, plan should include processes for cold chain management, if necessary to the incident. If public health will be using outside vendors for transportation, there should be a written process for initiating transportation agreements (e.g., contracts, memoranda of understanding, formal written agreements, and/or other letters of agreement). Transportation agreements should include, at a minimum, the following elements:

- Type of vendor (commercial vs. government)
- Number and type of vehicles, including vehicle load capacity and configuration
- Number and type of drivers, including certification of drivers
- Number and type of support personnel
- Vendor's response time
- Vendor's ability to maintain cold chain, if necessary to the incident

In addition to this process, public health should have written evidence of a relationship with outside transportation vendors. This relationship may be demonstrated by a signed transportation agreement or documentation of transportation planning meeting with the designated vendor.

P3: *(Priority)* Written plans should include protocols for medical and health-related agencies and organizations to report medical materiel levels to public health at least weekly, but potentially more frequently. (*For additional or supporting detail, see Capability 6: Information Sharing)*

Function 2: Acquire medical materiel

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process to request medical materiel (initial request and re-supply requests), including memoranda of understanding and mutual aid agreements with state/local partners if applicable. These plans should consider the following elements:

- Assessment of local inventory/medical countermeasure caches
- Identification of local pharmaceutical and medical-supply wholesalers
- Assessment of asset request trigger indicators, thresholds, and validation strategies to guide decision-making
- A process for requesting medical countermeasures through the Emergency Management Assistance Compact
- A process for requesting medical countermeasures from the federal level, which takes into account
  - □ Stafford Act vs. non-Stafford Act declarations
  - □ National Emergencies Act
  - □ Coordination between federal and state resources, including memoranda of understanding between CDC and the state
  - □ Role of U.S. Department of Health and Human Services Regional Emergency Coordinators, if necessary to the incident: http://www.phe.gov/Preparedness/responders/rec/Pages/contacts.aspx
- A process for justifying medical countermeasure requests
- If sites decide to purchase their own medical countermeasures, they are required to meet regulatory standards (i.e., abide by U.S. Food and Drug Administration standards including current good manufacturing practices (cGMP), have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation)

Function 3: Maintain updated inventory management and reporting system

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for reporting to jurisdictional, state, regional, and federal authorities. At a minimum, report should include the following elements:

- Amount of materiel received (including receipt date/time and name of individual who accepted custody of materiel)
- Amount of materiel distributed
- Amount of materiel expired
- Current available balance of materiel

(For additional or supporting detail, see Capability 6: Information Sharing)

Function 4: Establish and maintain security

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols that address the maintenance of physical security of medical countermeasures throughout acquisition, storage, and distribution, and include, at a minimum, the following elements:

- Contact information for security coordinator
- Coordination with law enforcement and security agencies to secure personnel and facility
- Acquisition of physical security measures (e.g., cages, locks, and alarms) for materiel within the receiving site
- Maintenance of security of medical materiel in transit

Function 5: Distribute medical materiel

Priority Resource Elements:

P1: *(Priority)* Written plans should include an allocation and distribution strategy including delivery locations, routes, and delivery schedule/frequency, and should take into consideration the transport of materials through restricted areas. The strategy should also consider whether recipients will be responsible for acquiring materiel from an intermediary distribution site or if the health department is responsible for delivering materiel.

Function 6: Recover medical materiel and demobilize distribution operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for the storage, distribution, disposal, or return of unused (unopened) medical materiel, unused pharmaceuticals, and durable items, including plans for maintaining integrity of medical materiel during storage and/or distribution within the jurisdictional health system.

Capability 10: Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Assess the nature and scope of the incident

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of staff assigned and trained in advance to fill public health incident management roles as applicable to a given response. Health departments must be prepared to staff emergency operations centers at agency, local, and state levels as necessary. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P2: *(Priority)* Written plans should include documentation that all joint (e.g., healthcare organizations, public health, and emergency management) emergency incidents, exercises, and preplanned (i.e., recurring or special) events operate in accordance with Incident Command Structure organizational structures, doctrine, and procedures, as defined in the National Incident Management System. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P3: *(Priority)* Written plans should include process to ensure access into the

jurisdiction's bed-tracking system to maintain visibility of bed availability across the jurisdiction.

P4: *(Priority)* Written plans should include processes to engage in healthcare coalitions and understand the role that each coalition partner will play to obtain and provide situational awareness. Coalitions are not expected to replace or relieve healthcare systems of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the state or local jurisdiction. The purpose of jurisdictional healthcare coalitions is as follows:

- Integrate plan and activities of all participating healthcare systems into the jurisdictional response plan and the state response plan
- Increase medical response capabilities in the community, region and state
    - □ Prepare for the needs of at-risk individuals and the general population in their communities in the event of a public health emergency
    - □ Coordinate activities to minimize duplication of effort and ensure coordination among federal, state, local and tribal planning, preparedness, response, and de-escalation activities
    - □ Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations
    - □ Unify the management capability of the healthcare system to a level that will be necessary if the normal day-to-day operations and standard operating procedures of the health system are overwhelmed, and disaster operations become necessary
    - □ Support sufficient jurisdiction-wide situational awareness to ensure that the maximum number of people requiring care receive safe and appropriate care, which may involve, but is not limited to, facilitating the triage and/or distribution of people requiring care to appropriate facilities throughout the jurisdiction and providing appropriate support to these facilities to support the provision of optimal and safe care to those individuals

P5: *(Priority)* Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care. Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers. *(For additional or supporting detail, see Capability 1: Community Preparedness)*

Function 2: Support activation of medical surge

Priority Resource Elements:

P1: *(Priority)* Written plans should include the following elements:

- Documentation of process or protocol for how the health agency will access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the

Medical Reserve Corps program of credentialed personnel available for assistance during an incident.
- Documentation of processes for coordinating with health professional volunteer entities (e.g., MRC) and other personnel resources from various levels. (ESAR-VHP Compliance Requirements)

(For additional or supporting detail, see Capability 15: Volunteer Management)

P2: *(Priority)* Written plans should include documentation of the process for how the public health agency will engage in healthcare coalitions and other response partners regarding the activation of alternate care systems. Documentation should also include the following elements:

- Written list of healthcare organizations with alternate care system plans
- Written list of home health networks and types of resources available that are able to assist in incident response
- List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility

(For additional or supporting detail, see Capability 7: Mass Care)

P3: *(Priority)* Written plans should include processes and protocols to identify essential situational awareness information for federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function # 8 partners. Jurisdictional processes to identify essential situational awareness requirements should consider the following elements:

- Identifying essential information
- Defining required information
- Establishing requirements
- Determining common operational picture elements
- Identifying data owners
- Validating data with stakeholders

(For additional or supporting detail, see Capability 6: Information Sharing)

P4: *(Priority)* Written plans should include documentation of participation from jurisdictional and regional pediatric providers and leaders from a variety of settings (e.g., maternal and child health programs, clinic-based, hospital-based, home healthcare, and rehabilitation) in jurisdictional response planning. Plans should include but are not limited to the following elements:

- Process to identify gaps in the provision of pediatric care
- Process to access pediatric providers or pediatric medical liaisons for consultation related to clinical care. In order to access the appropriate level of care or consultation, plans should include lists of healthcare organizations that can stabilize and/or manage pediatric traumatic and medical emergencies and that have written inter-facility transfer agreements that cover pediatric patients.

Function 3: Support jurisdictional medical surge operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to communicate situational awareness information to federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8

partners at least weekly, but potentially more frequently (e.g., as often as once per operational period). *(For additional or supporting detail, see Capability 6: Information Sharing)*

P2: *(Priority)* Written plans should include documentation that public health participates in the development and execution of healthcare coalition plans to address the functional needs of at-risk individuals. Plans should include a written list of healthcare organizations and community providers that are able to address the functional needs for at-risk individuals and a process to communicate with healthcare organizations and community providers to maintain a current list of available services that support the functional needs of at-risk individuals. *(For additional or supporting detail, see Capability 1: Community Preparedness)*

P3: *(Priority)* Written plans should include processes to support or implement family reunification. Considerations should include the following elements:

- Capturing and transferring the following known identification information throughout the transport continuum:
  - □ Pickup location (e.g., cross streets, latitude & longitude, and/or facility/school)
  - □ Gender and name (if possible)
  - □ For nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child.
  - □ Keep the primary caregiver (e.g., parents, guardians, and foster parents) with the patient to the extent possible

Function 4: Support demobilization of medical surge operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process for the jurisdiction to coordinate with state emergency medical services to demobilize transportation assets used in the incident.

P2: *(Priority)* Written plans should include a process to demobilize surge staff to include other state (e.g., MRC) and federal medical resources (e.g., NDMS). Process should include identification of triggers that would identify the need for demobilization. *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Capability 11: Non-Pharmaceutical Interventions

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

- Isolation and quarantine
- Restrictions on movement and travel advisory/warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Engage partners and identify factors that impact non-pharmaceutical interventions

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of the applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing non-pharmaceutical interventions in both routine and incident-specific situations. This includes but is not limited to authorities for restricting the following elements:

- Individuals
- Groups
- Facilities
- Animals (e.g., animals with infectious diseases and animals with exposure to environmental, chemical, radiological hazards)
- Consumer food products
- Public works/utilities (e.g., water supply)
- Travel through ports of entry

Public health departments are strongly encouraged to consult with jurisdictional legal counsel or academic centers for assistance. If applicable by jurisdictional authority, develop written memoranda of understanding or other letters of agreement with law enforcement for enforcing mandatory restrictions on movement.

P2: *(Priority)* Written plans should include documentation of the following elements:

- Contact information of at least two representatives from each partner agency/organization
  - Suggested community partners: schools, community organizations (e.g., churches and homeless shelters), businesses, hospitals, and travel/transportation industry planners
- Memoranda of understanding or other written acknowledgements/agreements with community partners outlining roles, responsibilities, and resources in non-pharmaceutical interventions
- Agreements with healthcare providers which must include at a minimum:
  - Procedures to communicate case definitions determined by epidemiological surveillance
  - Procedures for reporting identified cases of inclusion to the health department

  (For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)
- Suggested partners: Conference of Radiation Control Program Directors: http://www.crcpd.org, other radiation subject matter experts, health physicists, state environmental protection agency, U.S. Department of Energy, and U.S. Department of Agriculture

Function 2: Determine non-pharmaceutical interventions

Priority Resource Elements:

P1: *(Priority)* Written plans should include a jurisdictional non-pharmaceutical

intervention "playbook" detailing plans for intervention recommendation and/or implementation, based on potential interventions identified from the jurisdictional risk assessment. Suggested categories of interventions include isolation, quarantine, school and child care closures, workplace and community organization/event closure, and restrictions on movement (e.g., port of entry screenings and public transportation). Each plan should address the following items, at a minimum:

- Staff and subject matter expert roles and responsibilities
- Legal and public health authorities for the intervention actions
- Intervention actions
- List of identified locations that have the specific equipment required for, or locations that are easily adaptable for the intervention
- Contact information/notification plan of community partners involved in intervention (e.g., those providing services or equipment)
- Identification of any issues that may be associated with the implementation of individual community-mitigation measures or the net effect of the implementation of measures (secondary effects)
- Intervention-specific methods for information dissemination to the public (e.g. information cards to be distributed at ports of entry during movement restrictions)
- Processes for de-escalation of intervention once it is no longer needed
- Documentation of the intervention during an incident

(For additional or supporting detail, see Capability 1: Community Preparedness and Capability 4: Emergency Public Information and Warning)

Function 3: Implement non-pharmaceutical interventions

Priority Resource Elements:

P1: (*Priority)* Written plans should include agreements with healthcare coalitions and other community partners to coordinate support services to individuals during isolation or quarantine scenarios. *(For additional or supporting detail, see Capability 10: Medical Surge)*

P2: *(Priority)* Written plans should include procedures to support the separation of cohorts of potentially exposed travelers from the general population at ports of entry. Plans should include but are not limited to the following elements:

- Identification of resources (e.g., staff, facilities, and equipment) at or near ports of entry to be used for separation of cohorts
- Scalable plans to accommodate cohorts of various sizes in identified facilities
- Local and state Communicable Disease Response Plan compatible with CDC's Division of Global Migration and Quarantine guidance
- Applicable state/local legal authorities for detention, quarantine, and conditional release of potentially exposed persons and isolation of ill persons
- Processes for transportation of cohorts to, and security at, pre-identified sites

Function 4: Monitor non-pharmaceutical interventions

Capability 12: Public Health Laboratory Testing
Definition: Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This capability supports routine surveillance, including pre-event or pre-incident and post-exposure activities.

Functions: This capability consists of the ability to perform the functions listed below.
Function 1: Manage laboratory activities

Priority Resource Elements:

P1: *(Priority)* Written plans must include at a minimum the identification of laboratories and laboratory networks within the jurisdiction as well as procedures for interaction with the following laboratories and groups:

- LRN-B reference laboratories within the jurisdiction
  - Support and ensure LRN-B reference laboratory communication with all LRN-B sentinel and all other LRN-B reference laboratories within the jurisdiction
- CDC's LRN chemical (LRN-C) laboratories within the jurisdiction
- CDC's LRN radiological (LRN-R) laboratories within the jurisdiction (if program funds become available)
- Other state laboratories within the jurisdiction
  - e.g., non-LRN public health, environmental, agricultural, veterinary, and university laboratories
- Federal laboratory networks and member laboratories within the jurisdiction
  - e.g., the Food Emergency Response Network, National Animal Health Laboratory Network, and the Environmental Response Laboratory Network
- Poison control centers for chemical or radiological exposure incidents, such as food poisoning

P2: *(Priority)* Written plans must include the following elements:

- Documented procedures for contacting sentinel laboratories in the event of a public health incident
- Coordination of jurisdiction-wide stakeholders involved in chemical, biological, radiological, nuclear, and explosive response and their standard response guidelines
  - e.g., American Society for Testing and Material, Operational Guidelines for Initial Response to a Suspected BioThreat Agent

Function 2: Perform sample management

Priority Resource Elements:

S1: *(Priority)* Laboratory staff responsible for sample management must maintain

certification of laboratory personnel in a shipping and packaging program that meets national and state requirements (e.g., Sample Collection, Packing and Shipping; ShipPack).

Function 3: Conduct testing and analysis for routine and surge capacity

Priority Resource Elements:

P1: *(Priority)* Written plans should include the following considerations for surge capacity:

- Options to optimize procedures based on regular and surge personnel, equipment, and facility resources for short-term (e.g., days) and long-term (e.g., weeks to months) response efforts. Options should also be based on best practices and models available on the LRN website or other sources.
- Triage policies that address how the laboratory will manage surge testing, that may include:
  - □ Referral of samples to other jurisdictional laboratories
  - □ Prioritization of testing based upon sample type
  - □ Prioritization of testing based upon risk or threat assessment
  - □ Contingencies to assure newborn screening in a surge situation. Newborn screening can be assured by memoranda of agreement or contracts with commercial vendors
- Ensuring that laboratory testing and reporting can be performed for extended shifts based on need for Level 1 and Level 2 LRN-C laboratories. *(Not applicable for territories)*
- Ensuring that laboratory testing, quality assurance and control review, and reporting can be performed for extended shifts based on need for LRN-R laboratories, if program funds become available

P2: *(Priority)* Written plans should include preventative maintenance contracts and service agreements in place for equipment and instruments utilized in LRN protocols, procedures, and methods – at a minimum. Plans should also include protocols to ensure that equipment and instruments utilized in LRN protocols, procedures, and methods have been inspected and/or certified according to manufacturer's specifications.

S1: *(Priority)* Laboratories participating in radiological or nuclear testing must attain LRN-R (if program funds become available) Proficiency Testing Program Qualified status for all analysis methods transferred by LRN-R through the following:

- Attending LRN–R training, if program funds become available
- Completing the associated laboratory validation exercise, demonstrating performance and precision according to the minimum standards for each analytical method

S2: *(Priority)* LRN-B reference laboratories must attain competency for LRN-B testing methods by having the ability to test for all agents/sample types/tests listed in the high risk environmental sample testing algorithm posted on the secure LRN website.

S3: *(Priority)* All LRN Laboratories (excluding LRN-B sentinel laboratories) must maintain the competency to pass LRN proficiency tests.

S4: *(Priority)* Laboratories participating in chemical testing must attain LRN-C Proficiency Testing Program Qualified status, through the ability to perform the following:

- Core LRN-C methods testing, for all Level 1 (surge capacity laboratories only) and Level 2 analysis methods transferred by CDC. Core LRN-C methods are identified on the LRN website and updated at least annually.
- Validation and qualification of at least one new analysis method per year is required.

Function 4: Support public health investigations

Function 5: Report results

Priority Resource Elements:

E1: *(Priority)* Each LRN laboratory will build or acquire and configure a jurisdictional Laboratory Information Management System (LIMS) with the ability to send testing data to CDC according to CDC-defined standards. (This will reduce the duplicate entry into multiple data exchange systems, i.e., having to put data into results messenger or other data exchange systems to be able to send to CDC, public health partners, and other submitters). Configuring the LIMS includes the following elements:

- Developing project plans with deliverables and a timeline to achieve ability to send and receive data from local Laboratory Information Management Solution (LIMS) to CDC and other partners
- Mapping local codes to federal standards (e.g., LRN-B Test Configuration and Vocabulary Requirements, LRN-B Laboratory Results Message Guide)
- Working with IT support staff or developing contractual agreements with LIMS vendors that are familiar with federal (e.g., LIMS integration, Public Health Laboratory Interoperability Project) and industry (e.g., logical observation identities, names, and codes; systematized nomenclature of medicine; HL 7) standards to configure the LIMS
- Validating function of LIMS and structure of message by being able to send a test message to CDC
- Ensuring health information infrastructure and surveillance systems are able to accept, process, and analyze standards-based electronic messages from sending electronic health records (EHRs) as defined by Centers for Medicare & Medicaid Services (42 Code of Federal Regulations Parts 412, 413, 422 et al.) Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule (published on July 28, 2010 in the Federal Register at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf) and the Office of the National Coordinator for Health Information Technology (45 Code of Federal Regulations Part 170) Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Final Rule (published on July 28, 2010 in the Federal Register at http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf and

http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_3/20765)

Capability 13: Public Health Surveillance and Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Conduct public health surveillance and detection

Priority Resource Elements:

P1: *(Priority)* Written plans should document the legal and procedural framework that supports mandated and voluntary information exchange with a wide variety of community partners, including those serving communities of color and tribes.

P2: *(Priority)* Written plans should include processes and protocols for accessing health information that follow jurisdictional and federal laws and that protect personal health information via instituting security and confidentiality policies. *(For additional or supporting detail, see Capability 6: Information Sharing)*

P3: *(Priority)* Written plans should include processes and protocols to gather and analyze data from the following:

- Reportable condition surveillance (i.e., conditions for which jurisdictional law mandates name-based case reporting to public health agencies). Jurisdictions should plan to receive Electronic Laboratory Reporting for reportable conditions from healthcare providers using national Meaningful Use standards. *(For additional or supporting detail, see Capability 6: Information Sharing)*
- Syndromic surveillance systems. Jurisdictions are encouraged to establish or participate in such systems to monitor trends of illness or injury, and to provide situational awareness of healthcare utilization
    - Participation in the CDC BioSense data-sharing program is encouraged *(For additional or supporting detail, see Capability 6: Information Sharing)*
- Surveillance of major causes of mortality, including the use of vital statistics as a data source *(For additional or supporting detail, see Capability 5: Fatality Management)*
- Surveillance of major causes of morbidity
- Written plans should be able to adapt to include novel and/or emerging public health threats.

Gathering and analyzing data from the following sources should also be taken into consideration:

- Environmental conditions
- Hospital discharge abstracts
- Information from mental/behavioral health agencies

- Population-based surveys
- Disease registries
- Immunization registries/Immunization information systems
- Active case finding (e.g., by healthcare logs and record reviews)

(For additional or supporting detail, see Capability 1: Community Preparedness, Capability 6: Information Sharing, and Capability 10: Medical Surge)

P4: *(Priority)* Written plans should include procedures to ensure 24/7 health department access (e.g., designated phone line or contact person in place to receive reports) to collect, review, and respond to reports of potential health threats. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P5: *(Priority)* Written plans should include processes and protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List within the time frame identified on the list, including immediate notification when indicated. Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. Plans should include procedures to move to electronic case notification using CDC's Public Health Information Network Case Notification Message Mapping Guides.

S1: *(Priority)* Public health staff conducting data collection, analysis, and reporting in support of surveillance and epidemiologic investigations should achieve, at a minimum, the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.

- When creating new surveillance systems, consideration should be given to securing assistance (e.g., from academic institutions or state-level staff) from individuals with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
- Note: Formal educational degree requirement and masters' degree supervision requirement is suggested but not required.

E1: *(Priority)* Have or have access to health information infrastructure and surveillance systems that are able to accept, process, analyze, and share data for surveillance and epidemiological investigation activities. *(For additional or supporting detail, see Capability 6: Information Sharing)*

- Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. *(For additional or supporting detail, see Capability 6: Information Sharing)*

Function 2: Conduct public health and epidemiological investigations

Priority Resource Elements:

P1: *(Priority)* Written plans should include investigation report templates that contain the following minimal elements:

- Context / Background – Information that helps to characterize the incident, including the following:
  - □ Population affected (e.g., estimated number of persons exposed and number of persons ill)
  - □ Location (e.g., setting or venue)
  - □ Geographical area(s) involved
  - □ Suspected or known etiology
- Initiation of Investigation – Information regarding receipt of notification and initiation of the investigation, including the following:
  - □ Date and time initial notification was received by the agency
  - □ Date and time investigation was initiated by the agency
- Investigation Methods - Epidemiological or other investigative methods employed, including the following:
  - □ Any initial investigative activity (e.g., verified laboratory results)
  - □ Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental)
  - □ Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, and questionnaires)
  - □ Case definitions (as applicable)
  - □ Exposure assessments and classification
  - □ Review of reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires
- Investigation Findings/Results - all pertinent investigation results, including the following:
  - □ Epidemiological results
  - □ Laboratory results (as applicable)
  - □ Clinical results (as applicable)
  - □ Other analytic findings (as applicable)
- Discussion and/or Conclusions – analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a Conclusions section without a Discussion section may be sufficient
- Recommendations for Controlling Disease and/or Preventing/Mitigating Exposure – specific control measures or other interventions recommended for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure
- Key investigators and/or report authors – names and titles are critical to ensure that lines of communication with partners, clinicians, and other stakeholders can be established.

S1: *(Priority)* Maintain staffing capacity to manage the routine epidemiological investigation systems at the jurisdictional level as well as to support surge epidemiological investigations in response to natural or intentional threats or incidents. This is accomplished through the following:

- Surge staff should be competent in Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies
- Consideration should be given to securing assistance (e.g., academic institutions or state-level staff) from an individual with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies
- Note: Formal educational degree requirement and masters' degree supervision requirement is suggested but not required.

(For additional or supporting detail, see Capability 15: Volunteer Management)

Function 3: Recommend, monitor, and analyze mitigation actions

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents. Protocols include case and contact definitions, clinical management of potential or actual cases, the provision of medical countermeasures, and the process for exercising legal authority for disease, injury, or exposure control. Protocols should include consultation with the state or territorial epidemiologist when warranted. *(For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing and Capability 11: Non-Pharmaceutical Interventions*

S1: *(Priority)* Public health staff participating in epidemiological investigations should receive awareness-level training with the Homeland Security Exercise and Evaluation After Action Report process.

Function 4: Improve public health surveillance and epidemiological investigation systems

Priority Resource Elements:

P1: *(Priority)* Written plans should include procedures to communicate the improvement plan to key stakeholders (including groups representing at-risk populations) and to implement corrective actions identified in the improvement plan.

Capability 14: Responder Safety and Health

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Identify responder safety and health risks

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of the safety and health

risk scenarios likely to be faced by public health responders, based on pre-identified jurisdictional incident risks, which are developed in consultation with partner agencies (e.g., environmental health, occupational health and safety, jurisdictional Local Emergency Planning Committee, risk-specific subject matter experts). This documentation should include the following elements:

- Limits of exposure or injury necessitating response
- Job-specific worker safety guides (e.g., radiation, heat, fire, and infrastructure damage resulting in other chemical release)
- Potential for post-event medical and mental/behavioral health follow-up assessments

P2: *(Priority)* Written plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction's identified risks, that was developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and hazard-specific subject matter experts) and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders will need to have to execute potential roles. Roles for consideration may include the following elements:

- Conducting environmental health assessments
- Potable water inspections
- Field surveillance interviews

Recommend inclusion of the following groups, at a minimum:

- State versions of Environmental Protection Agency
- State Radiation Control Programs: http://www.crcpd.org/Map/RCPmap.htm
- State Occupational Safety and Health Agency

Function 2: Identify safety and personal protective needs

Priority Resource Elements:

P1: *(Priority)* Written plans should include recommendations for risk-related personal protective equipment for public health responders that have been developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and risk-specific subject matter experts).

E1: *(Priority)* Have or have access to personal protective equipment that is consistent with the identified risks in the jurisdiction and associated job functions of public health response personnel. This equipment should meet nationally recognized standards as defined by the InterAgency Board for Equipment Standardization and Interoperability (https://iab.gov).

Note: If public health departments elect to purchase personal protective equipment for their responders, they must follow state, Occupational Safety and Health Administration, CDC's National Institute for Occupational Safety and Health, and other applicable regulations regarding the storage, dissemination, fit testing, and maintenance of such personal protective equipment.

Function 3: Coordinate with partners to facilitate risk-specific safety and health training

Priority Resource Elements:

S1: *(Priority)* Public health staff required to use N-95 or other respirators as part of their response role should undergo respiratory function testing.

S2: *(Priority)* Public health staff that perform responder functions, as well as staff identified as surge-capacity personnel, should have documentation of training, with documentation updated a minimum of once per year. Documentation should include training date and manner of delivery (e.g., formal training or "train the trainer"). Formal training examples include CDC courses and CD or DVD-based courses, with completion verified by a formal demonstration.

Function 4: Monitor responder safety and health actions

Priority Resource Elements:

P1: *(Priority)* Written plans should include process and protocols for how the public health agency, in conjunction with lead partners (e.g., occupational health and safety) will participate in surveillance activities to monitor levels of environmental exposure, environmental effects on the responders, and/or incident-related injuries. *(For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)*

E1: *(Priority)* Have or have access to a registry database of responders who were exposed and/or injured during an incident. This database should be updated at a frequency appropriate to the incident.

Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

Function 1: Coordinate volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should address anticipated volunteer needs in response to incidents or situations identified in the jurisdictional risk assessment including the following elements:

- Identification of functional roles
- Skills, knowledge, or abilities needed for each volunteer task or role
- Description of when the volunteer actions will happen
- Identification of jurisdictional authorities that govern volunteer liability issues and scope of practice

P2: *(Priority)* Written plans should include memoranda of understanding or other letters of agreement with jurisdictional volunteer sources. Suggested partners include but are not limited to the following groups:

- Professional medical organizations (e.g., nursing and allied health)

- Professional guilds (e.g., behavioral health)
- Academic institutions
- Faith-based organizations
- Voluntary Organizations Active in Disasters
- Medical Reserve Corps
- Non-profit, private, and community-based volunteer groups

Partnership agreements should include plans for the following:

- Partner organizations' promotion of public health volunteer opportunities
- Referral of all volunteers to register with jurisdictional Medical Reserve Corps and/or ESAR-VHP
- Policies for protection of volunteer information, including destruction of information when it is no longer needed (e.g., Red Cross, Community Emergency Response Teams, and member organizations of the National and State Voluntary Organizations Active in Disasters)
- Liability protection for volunteers
- Efforts to continually engage volunteers through routine community health activities
- Documentation of the volunteers' affiliations (e.g., employers and volunteer organizations) at local, state, and federal levels (to assist in minimizing "double counting" of prospective volunteers), and provision for registered volunteer Identification cards denoting volunteers' area of expertise

Function 2: Notify volunteers

Function 3: Organize, assemble, and dispatch volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should include a template for briefing volunteers of current incident conditions, including the following elements:

- Instructions on the current status of the emergency
- Volunteers' role (including how the volunteer is to operate within incident management)
- Just-in-time training
- Safety instructions
- Any applicable liability issues related to the incident and the volunteers' roles, psychological first aid, and/or volunteer stress management

P2: *(Priority)* Written plans should include a process to manage spontaneous volunteers. The process should include, at a minimum, the following elements:

- Process to communicate to the public whether spontaneous volunteers should report, and, if so, where and to whom
- Method to inform spontaneous volunteers how to register for use in future emergency responses
- Method to refer spontaneous volunteers to other organization (e.g., non-profit or Medical Reserve Corps)

(For additional or supporting detail, see Capability 4: Emergency Public

Information and Warning)
If spontaneous volunteers will be integrated into a response, the process should include the identification of duties spontaneous volunteers can perform.

Function 4: Demobilize volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process for releasing volunteers, to be used when the public health department has the lead role in volunteer coordination. The process should include steps to accomplish the following:

- Demobilize volunteers in accordance with the incident action plan
- Assure all assigned activities are completed, and/or replacement volunteers are informed of the activities' status
- Determine whether additional volunteer assistance is needed from the volunteer
- Assure all equipment is returned by volunteer
- Confirm the volunteer's follow-up contact information

(For additional or supporting detail, see Capability 4: Emergency Operations Coordination)

P2: *(Priority)* Written plans should include a protocol for conducting exit screening during out-processing, to include documentation of the following:

- Any injuries and illnesses acquired during the response
- Mental/behavioral health needs due to participation in the response
- When requested or indicated, referral of volunteer to medical and mental/behavioral health services

(For additional or supporting detail, see Capability 14: Responder Safety and Health)

Appendix 6
Budget Period 1 (Fiscal Year 2012)
HPP-PHEP Performance Measures (Provisional)[6]

Capability	Performance Measures
Information Sharing	**HPP-PHEP 6.1: Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe**
Volunteer Management	**HPP-PHEP 15.1: Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe**

[6] HPP and PHEP awardees are required to report on the joint measures at mid-year and at the end of the budget period.

Appendix 7
Budget Period 1 (Fiscal Year 2012)
Hospital Preparedness Program Performance Measures (Provisional)[7]

Capability	Performance Measures
Healthcare System Preparedness	**HPP 1.1: Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Healthcare System Recovery	**HPP 2.1: Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Emergency Operations Coordination	**HPP 3.1: Percent of healthcare coalitions (HCCs) that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Fatality Management	**HPP 5.1: Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities.** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Information Sharing	**HPP 6.1: Percent of healthcare coalitions (HCCs) that can continuously monitor Essential Elements of Information (EEIs) and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

[7] HPP awardees are required to report annually on all measures specific to the HPP program at mid-year and at the end of the budget period.

Medical Surge	**HPP 10.1: Percent of healthcare coalitions (HCCs) that have a coordinated mechanism in place to provide an appropriate level of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients) that includes providing bed availability 20% above the daily census within 4 hours of a disaster** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Responder Safety and Health	**HPP 14.1: Percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees)** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**
Volunteer Management	**HPP 15.1: Percent of healthcare coalitions (HCCs) that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident.** **Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)**

Appendix 8
Budget Period 1 (Fiscal Year 2012)
Hospital Preparedness Program
Evidence-Based Benchmarks Subject to Withholding

	PAHPA Benchmark
S1	The Awardees submit timely and complete data for the midyear report, the end-of-year report, and the final Federal Financial Report (FFR).
S2	The State EOC can electronically report available and staffed beds according to HAvBED definitions by sub-state regions to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current grant year. These reports should reflect bed data from at least 75% of participating facilities in the state.
S3	Awardees shall develop and submit exercise plans that must include a proposed exercise schedule and a discussion of the plans for healthcare entity exercise development, conduct, evaluation, and improvement planning. This exercise plan must demonstrate participation by healthcare coalitions and the participating hospitals to include the participating organizations and anticipated capabilities to be tested.
S4	Awardees will submit a comprehensive inventory that lists each of its participating hospitals by name and by National Provider Identifier (NPI) (formerly known as HIPAA ID); identifies each of the 11 NIMS implementation activities that have been achieved; and identifies each activity still in progress. This must also include the plans to address the gaps for the identified hospitals that are not 100% compliant with NIMS requirements

Appendix 9
Budget Period 1 (Fiscal Year 2012)
Public Health Emergency Preparedness Performance Measures[8]

Capability	Performance Measure
Community Preparedness	**Median number of community sectors in which LHDs identified key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts**
	Median number of community sectors that LHDs engaged in using hazards, and vulnerabilities assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services
	Proportion of key organizations that LHDs engaged in a significant public health emergency preparedness activity
	Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services
Emergency Operations Coordination (EOC)	**Time for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for immediate duty**
	Production of the approved Incident Action Plan (IAP) before the start of the second operational period
	Time to complete a draft of an After Action Report (AAR) and Improvement Plan (IP)
Emergency Public Information and Warning	**Time to issue a risk communication message for dissemination to the public**
Fatality Management	**Percent of local health departments that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors)** **The directly funded city has defined fatality management roles and responsibilities of public health in relationship to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors) (Y/N)** **The US Affiliated Island Jurisdiction (USAIJ) has defined fatality management roles and responsibilities of public health in relationship to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors) (Y/N)**
Information Sharing	**Proportion of local health departments that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs)**

[8] PHEP performance measures data need only be reported by those awardees as detailed in Table 1.

	The directly funded city can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs) (Y/N) **The US Affiliated Island Jurisdiction (USAIJ) can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs) (Y/N)**

Medical Countermeasure Dispensing and Medical Material Management and Distribution	**Medical Countermeasure Distribution and Dispensing (MCMDD) composite measure**
	MCMDD composite measure score will be calculated annually based on performance data collected from the following preparedness activities:
	• Technical Assistance Review
	• DSNS operational drills
	• Compliance with programmatic standards
	  ○ Points of dispensing standards data submission
	  ○ Medical countermeasure distribution standards data submission
	• Full-scale exercises (FSE)
	  ○ Medical countermeasure distribution
	  ▪ States and directly funded localities are required to perform one FSE within the 2011-2016 performance period. Islands, territories and freely associated states are encouraged but not required to perform a FSE.
	  ○ Medical Countermeasure dispensing
	  ▪ Each CRI local jurisdiction, including the directly funded localities are required to perform one FSE within the 2011-2016 performance period. Islands, territories and freely associated states are encouraged but not required to perform a FSE.

Public Health Lab Testing (PHLT)	**(Bio Only): Time for sentinel clinical laboratories to acknowledge receipt of an urgent message from PHEP-funded laboratory**
	(Bio and Chem): Time for initial laboratorian to report for duty at the PHEP-funded laboratory
	(Bio and Chem): Time to complete notification between CDC, on-call laboratorian, and on-call epidemiologist **Performance Target: 45 minutes**
	(Bio and Chem): Time to complete notification between CDC, on-call epidemiologist, and on-call laboratorian **Performance Target: 45 minutes**
	(Chem only): Ability of PHEP-funded LRN-C Level 1 and/or Level 2 laboratories to detect and quantify biomarkers of chemical agents in clinical samples during the LRN Emergency Response Pop Proficiency Test (PopPT) Exercise
	(Bio only): Ability of PHEP-funded LRN-B reference laboratory to contact the CDC Emergency Operations Center within 2 hours during LRN notification drill

	(Bio and Chem): Time for PHEP-funded laboratory to notify public health partners of significant laboratory results
	(Bio Only): Proportion of LRN-B proficiency tests successfully passed by PHEP-funded laboratories
	(Chem Only): Proportion of LRN-C proficiency tests (additional methods) successfully passed by PHEP-funded laboratory
	(Chem Only): Proportion of LRN-C proficiency tests (core methods) successfully passed by PHEP-funded laboratory
	(Chem Only): Ability of PHEP-funded LRN-C laboratory to collect, package, and ship samples properly during LRN exercise
	(Bio Only): Percentage of LRN nonclinical samples received at the PHEP-funded laboratory for confirmation or rule-out testing from first responders without any adverse quality assurance events
	(Bio Only): Percentage of LRN clinical specimens received at PHEP-funded laboratory for confirmation or rule-out testing from sentinel clinical laboratories without any adverse quality assurance events
	(Chem Only): Ability of each PHEP-funded LRN-C Level 1 laboratory to process and report results to CDC for 500 samples during the LRN Surge Capacity Exercise
Public Health Surveillance and Epidemiological Investigation	**Proportion of reports of selected reportable diseases received by a public health agency within the awardee-required timeframe**
	Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate timeframe
	Percentage of infectious disease outbreak investigations that generate reports
	Percentage of infectious disease outbreak investigation reports that contain all minimal elements
	Percentage of EI of acute environmental exposures that generate reports
	Percentage of EI reports of acute environmental exposures that contain all minimal elements
Volunteer Management	**Proportion of local health departments that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident** **The directly funded city has plans, processes and procedures in place to manage volunteers supporting a public health or medical incident (Y/N)** **The US Affiliated Island Jurisdiction (USAIJ) has plans, processes and procedures in place to manage volunteers supporting a public health or medical incident (Y/N)**

Table 1

Alignment of Capabilities to PHEP (and HPP-PHEP)Performance Measures and Required Reporting*

Note: Only those capabilities and functions with associated CDC-defined performance measures are included in this table.

Performance Measure	Requir	Applicable to

	ed for FY12 reporting	50 States	DC	LAC	NYC	CHI	Territories
Community Preparedness							
CP: Engagement in determining risk	X	X	X	X	X	X	X
CP: Identification of key organizations CP: Engagement in recovery planning	X	X	X	X	X	X	X
CP: Engagement in public health emergency preparedness	X	X	X	X	X	X	X
Emergency Operations Coordination							
EOC: Staff Assembly	X	X	X	X	X	X	X
EOC: IAP		X	X	X	X	X	X
EOC: AAR and IP	X	X	X	X	X	X	X
Emergency Public Information and Warning							
EPIW: Public Message Dissemination	X (new for FY12)	X	X	X	X	X	X
Fatality Management							
FM: Defined fatality management roles	X (MY)	X	X	X	X	X	X
Information Sharing							
IS: Share basic epidemiological and/or clinical data	X (MY)	X	X	X	X	X	X
IS (and Med Surge) (HPP-PHEP): Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe	X (MY)	X	X	X	X	X	X
Medical Countermeasure Dispensing							
MCMDD Composite Measure (DSNS)	X	Refer to MCMDD Guidance†					
Medical Materiel Management and Distribution							
MCMDD Composite Measure (DSNS)	X	Refer to MCMDD Guidance					
Public Health Laboratory Testing							
Lab [Bio]: Communication between awardee and sentinel clinical labs		X					

Lab [Bio & Chem]: Laboratorian Reporting		X	X	X	X		
Lab [Bio]: Sample quality - first responders	X	X					
Lab [Bio]: Specimen quality - sentinel clinical labs	X	X					
Lab [Chem]: Sample collection, packing and shipping (SCPaS)	X	Level 1, 2, and 3					
Lab [Bio]: Proficiency Testing	X	X	X	X	X		
Lab [Chem]: Proficiency Testing - Additional Methods	X	Level 1 – Required; Level 2 - Optional					
Lab [Chem]: Proficiency Testing - Core Methods	X	Level 1 and 2 labs are expected to participate					
Lab [Chem]: PopPT	X	Level 1 and 2 labs only					
Lab [Chem]: Surge Capacity Exercise	X	Level 1 labs only					
Emergency Contact Drill - CDC to Epi to Lab [Bio or Chem]	X	X	X	X	X		
Emergency Contact Drill - CDC to Lab [Bio or Chem] to Epi	X	X	X	X	X		
Lab [Bio & Chem]: Notification to Partners	X	X	X	X	X-Bio		
Lab [Bio]: Notification Drill Associated with PT	X	X	X	X	X-Bio		
Public Health Surveillance and Epidemiological Investigation							
SURV: Disease Reporting	X	X	X		X		
EI: Exposure Investigation Reports	X	X	X	X	X	X	X
EI: Exposure Reports with Minimal Elements	X	X	X	X	X	X	X
EI: Outbreak Investigation Reports	X	X	X	X	X	X	X
EI: Outbreak Reports with Minimal Elements	X	X	X	X	X	X	X
SURV: Disease Control	X	X	X		X		
Volunteer Management							
VM: Plans and Processes to manage volunteers	X (MY)	X	X	X	X	X	X
VM (HPP-PHEP):	X	X	X	X	X	X	X

Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe	(MY)						

X -The Division of State and Local Readiness will be collecting these data at end-of-year.
X – Bio -Only the biological lab needs to report this data
X – Chem – Only the chemical lab needs to report
MY – Requires mid-year data collection; end-of-year may be required for HPP-PHEP measures
* This table subject to change as additional PHEP performance measures are introduced for FY12 reporting (expected by June 2012)
† The Medical Countermeasure Distribution and Dispensing (MCMDD) Composite Measure Guide can be accessed and downloaded from the SNS Extranet site (www.bt.cdc.gov/stockpile/extranet) and the SNS SharePoint site (www.orau.gov/sns).

Appendix 10
Budget Period 1 (Fiscal Year 2012)
Public Health Emergency Preparedness
Evidence-Based Benchmarks Subject to Withholding

CDC has identified the following fiscal year 2012 benchmarks for Budget Period 1 to be used as a basis for withholding of fiscal year 2013 funding for PHEP awardees. As mandated by PAHPA, awardees that fail to "substantially meet" the benchmarks are subject to withholding of funds penalties to be applied the following fiscal year. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds.

1. Demonstrated adherence to all PHEP application and reporting deadlines. Failure to submit required PHEP program data and reports by the stated deadlines will constitute a benchmark failure. A failure to timely report key program data hinders CDC's ability to analyze data and submit accountability reports as required and jeopardizes CDC's ability to accurately reflect PHEP program achievements and barriers to success. This benchmark applies to all 62 awardees. Required data and reports include:
   - PHEP Budget Period 1 funding application due 60 calendar days following initial publication of the FOA and interim progress reports/noncompeting continuation funding applications for subsequent PHEP budget periods are due no less than 90 days before the end of the budget period;
   - PHEP Budget Period 1 mid-year progress reports, due 30 days after the first six months of the budget period, including status updates on PAHPA benchmarks and technical assistance plans; updates on current preparedness status and self-identified gaps based on the public health and healthcare preparedness capabilities as they relate to overall jurisdictional needs; and interim financial reports.
   - Annual PHEP Budget Period 1 progress report, due 90 days after the end of the budget period, including updates on work plan activities including local contracts, progress on implementation of technical assistance plans; budget expenditure reports; updates on PAHPA benchmarks and performance measurement activities; and preparedness accomplishments, success stories, and program impact statements.
   - PHEP Budget Period 1 financial report, no later than 90 days after the end of the budget period.

2. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency. As part of their response to public health emergencies, public health departments must be able to provide countermeasures to 100% of their identified population within 48 hours after the federal decision to do so. To achieve this standard, public health departments must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

Using the framework and tools currently available to assess the capabilities to receive, distribute and dispense medical countermeasures, CDC has developed a composite score as a measure to more accurately reflect preparedness and response capabilities within the 62 PHEP-funded jurisdictions.

The medical countermeasure distribution and dispensing (MCMDD) composite score serves as a more accurate indicator of preparedness and operational capability and will link preparedness results from dependent government sectors within the 62 PHEP-funded jurisdictions.

CDC will continue to conduct annual technical assistance reviews (TARs) of all 62 PHEP awardees with local, city, state, and territorial MCMDD preparedness being defined as a composite measure calculated from the results of annual TARs, operational drill submissions, a full-scale exercise, and data submissions as evidence of compliance with programmatic standards.

Using the results of state and/or local CRI planning and preparedness activities, CDC will compute an overall MCMDD composite measure score for each of the 62 awardees. During the progression from 2011 to 2016, PHEP awardees will be required to perform and/or submit documentation for a series of composite requirements to meet increasing MCMDD composite benchmarks. With the exception of the identified annual requirements, jurisdictions will have flexibility to determine the order in which they perform additional operational-based activities.

To demonstrate the current capacity and degree of advancement in emergency response capabilities during Budget Period 1, public health departments must comply with the following requirements and submit all required supporting documentation by May 1, 2013.

- The 50 states must meet a minimum overall MCMDD composite benchmark of **52** for Budget Period 1. The overall state composite score will include contribution from CRI local planning jurisdiction preparedness assessment and data submission and will be derived from:
  - DSNS state TAR conducted during Budget Period 1.
  - DSNS local TAR conducted within each planning/local jurisdiction within each CRI during Budget Period 1. When there are multiple planning/local jurisdictions with a CRI metropolitan statistical area, the DSNS is responsible for reviewing a minimum of 25% of the CRI jurisdictions, and the state is responsible for reviewing the remaining 75% of the CRI jurisdictions using the DSNS local TAR tool.
  - A minimum of three different drills (not the same drill performed three times) conducted within each planning/local jurisdiction within each CRI metropolitan statistical area (MSA) during Budget Period 1.
  - Compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide.

- At least one full-scale exercise conducted within the five-year performance period of 2011-2016 that tests and validates medical countermeasures distribution and dispensing plans. Results and documentation of medical countermeasure distribution and dispensing full-scale exercise(s) must be developed in accordance with **Homeland Security Exercise and Evaluation Program (HSEEP)** standards and can be performed during any one of five PHEP budget periods between 2011 and 2016. Each state will be required to participate in one exercise that demonstrates capabilities for medical countermeasure distribution operations, and each CRI MSA will be required to participate in one exercise that demonstrates capabilities for medical countermeasure dispensing operations. Each CRI MSA (including the four directly funded cities) dispensing exercise must include pertinent jurisdictional leadership and emergency support function leads, planning and/or operational staff in the exercise planning process and must incorporate participation from all CRI MSA jurisdictional partners in some form based on current capability assessment and needs. States and local jurisdictions are not required to coordinate performance of distribution and dispensing exercises but are encouraged to work together and with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives.

- The four directly funded localities must meet a minimum overall MCMDD composite benchmark of **57** for Budget Period 1. Directly funded locality composite scores will be derived from:
  - A DSNS local TAR conducted within directly funded local planning jurisdiction during Budget Period 1. DSNS is responsible for performing reviews for the directly funded localities.
  - A minimum of three different drills (not the same drill performed three times) conducted within each directly funded locality area during Budget Period 1.
  - Compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide.
  - Awardees will conduct one full-scale exercise that tests and validates medical supplies distribution and dispensing plans and submit results of documentation, developed in accordance with HSEEP standards. The full-scale exercise can be performed during any one of the five PHEP budget periods between 2011 and 2016. Each directly funded city will be required to participate in one CRI MSA exercise that demonstrates capabilities for medical countermeasure distribution and prophylaxis/dispensing operations. Directly funded cities are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives.

- American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Puerto Rico, Republic of the Marshall Islands, Republic of Palau, and the U.S. Virgin Islands must meet a minimum overall MCMDD composite benchmark of **36** for Budget Period 1. Composite scores will be derived from:
  - A DSNS TAR conducted within each planning jurisdiction during Budget Period 1. DSNS is responsible for performing reviews for Puerto Rico and the USAIJ.
  - A minimum of three different drills (not the same drill performed three times) conducted within each territory during Budget Period 1.
  - Compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide.
  - Awardees are encouraged but not required to conduct one full-scale exercise performed during any one of the five PHEP budget periods between 2011 and2016 to test and validate medical supplies distribution and dispensing plans. Awardees are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the collection of operational data and the requirements for submission of supporting documentation are in CDC's MCMDD Composite Guide.

The range in scope of available drills provides jurisdictions with flexibility to advance core capabilities and meet the annual drill requirements. The three drills can be chosen from any of the eight available drills as indicated on the CDC Division of Strategic National Stockpile (DSNS) extranet site. To receive credit for submission of operational-based drill performance and /or **Homeland Security Exercise and Evaluation Program (HSEEP)** after-action reports/improvement plans (as indicated), all data and supporting documentation must be submitted through the DSNS Web-based Data Collection System no later than May 1, 2013.

Detailed guidance on medical countermeasure distribution and dispensing standards, target measures, and metrics is provided in CDC's MCMDD Composite Measure Guide. The composite measure guide can be accessed and downloaded from the CDC DSNS extranet site at https://www.orau.gov/snsnet/resources/guidance/DSNS_MCMDD_Cooperative_Agreement_Guide_2011_V3.pdf. (Awardees should contact their DSNS program services consultants or state SNS coordinators to obtain SNS-provided user name and password required to access the site.)

Specifically:

- Each planning/local jurisdiction within each CRI area, each directly funded locality, territory, island, and freely associated state is required to submit data elements for all dispensing sites and modalities that have been identified within their jurisdiction to support a CRI mass prophylaxis scenario. POD informational

datasets must be submitted during Budget Period 1 through email to DSNS at SNS_PPB@cdc.gov and received on or before May 1, 2013. Data can be submitted using a range of database file systems and should identify the core preparedness measures indicated in CDC's MCMDD Composite Guide.

- Each state, directly funded locality, and territory will be required to submit data to document medical distribution warehouse infrastructure and capacity as evidence of compliance with medical countermeasure distribution standards. Submission of data to support compliance with the DSNS distribution standards is an optional activity during Budget Period 1.

3. Demonstrated ability to pass laboratory proficiency testing and/or exercises for biological and chemical agents.
   - **Awardees must ensure that Laboratory Response Network biological (LRN-B) laboratories pass proficiency testing.** CDC proficiency tests are composed of a number of unknown samples that are tested to evaluate the abilities of LRN reference and/or national biological laboratories to receive, test, and report on one or more suspected biological agents. To demonstrate this capability, the LRN-B laboratory must successfully pass CDC proficiency tests for all LRN agents/assays for which they have requested access to LRN-B reagents from CDC during each budget period.

     1. Successfully passed is defined as:
        a. The agent is detected or not detected in all samples as expected
        b. The lab follows the appropriate algorithm for testing samples and interpreting results
        c. The lab submits data to CDC within the prescribed deadline

     2. Using the definition as described above, CDC will use the following elements to calculate if the laboratory passed:
        a. Number of LRN-B proficiency tests successfully passed by the LRN-B laboratory during first attempt (numerator)
        b. Number of LRN-B proficiency tests participated in by the LRN-B laboratory (denominator)

     3. The minimum performance for each year of the PHEP project period is:
        a. Budget Period 1: Laboratory cannot miss more than two PT challenges
        b. Budget Periods 2-5: Laboratory cannot miss more than one PT challenge

     In Budget Period 1, the LRN-B proficiency testing (PT) benchmark is applicable to each of the 50 state public health laboratories (LRN-B reference laboratories), plus the LRN-B laboratories in Los Angeles County, New York City, and Washington, D.C. Although a lab that fails a challenge may retest (i.e., undergo remediation) for purposes of being able to continue to test for that agent, retests will not apply to the numerator for this benchmark.

- **Awardees must ensure that at least one LRN chemical (LRN-C) laboratory in their jurisdictions passes the sample collection, packaging, and shipping (SCPaS) exercise.**

  This annual exercise evaluates the ability of a laboratory to collect relevant samples for clinical chemical analysis and ship those samples in compliance with International Air Transport Association regulations. This benchmark applies to the 50 states and three directly funded localities (Los Angeles County, New York City, and Washington, D.C.). These awardees must ensure at least one LRN-C laboratory passes CDC's SCPaS exercise. If a laboratory fails the exercise on its first attempt but passes on the second attempt, then the awardee will meet the benchmark. If a PHEP awardee has multiple laboratories, at least one laboratory must participate and pass.

- **Awardees must ensure that LRN-C Level 1 laboratories pass proficiency testing in core and additional analysis methods**.

  This benchmark applies to the 10 awardees with Level 1 laboratories (California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin). Although this PAHPA benchmark does not apply to awardees with Level 2 laboratories, awardees with Level 2 laboratories must report on LRN-C proficiency testing performance measures as specified in PHEP performance measure guidance.

  LRN methods can help determine how widespread an incident is, identify who does/does not need long-term medical treatment, assist with nonemergency medical guidance, and help law enforcement officials determine the origin of the agent. Level 1 laboratories undergo proficiency testing to determine if they can rapidly detect and measure chemical agents that can cause severe health effects. CDC has identified nine core methods and four additional methods for detecting and measuring these agents and conducts testing to determine a laboratory's proficiency in these methods.

  The core methods are 1) arsenic in urine by DRC ICP-MS; 2) cadmium/lead/mercury in blood by ICP-MS; 3) cyanide in blood by GC-MS; 4) volatile organic chemicals (VOCs) in blood by SPME GC-MS; 5) nerve agent metabolites in urine by LC-MS/MS; 6) toxic elements by ICP-MS; 7) tetramine by GC-MS; 8) metabolic toxins by LC/MS/MS; and 9) plant toxins in urine by LC-MS/MS. Additional methods are 1) sulfur mustard metabolite in urine by LC-MS/MS; 2) Lewisite metabolite in urine by LC-ICP-MS; 3) nitrogen mustard metabolite in urine by LC-MS/MS; and 4) tetranitromethane biomarker in urine by LC-MS/MS.

  Level 1 laboratories must demonstrate proficiency in 90% of all core and additional LRN-C methods. Successfully passed is defined as obtaining an 80% score in two of the last three proficiency testing challenges for each method. To obtain a passing score, the laboratory must detect the agent, correctly quantify its results, and submit data to CDC within the prescribed deadline.

Influenza Pandemic Plans

Section 319C-1 of the PHS Act, as amended by PAHPA, currently requires that PHEP awardees annually submit influenza pandemic plans. CDC will provide further information on the 2012 submission in a separate guidance document. Section 319C-1 also requires withholding of funding from PHEP awardees that fail to submit acceptable pandemic influenza operations plans each fiscal year.

Table 1: Criteria to Determine Potential Withholding of PHEP Fiscal Year 2013 Funds

	Benchmark Measure	**Yes**	**No**	**Possible % Withholding**
1	Did the awardee (all awardees) meet all application and reporting deadlines?			10%
2	Did the awardee (all awardees) demonstrate capability to receive, stage, store, distribute, and dispense material during a public health emergency?			
3	Did the applicable awardee demonstrate proficiency in public health laboratory testing and/or exercises for biological and chemical agents?			
4	Did the awardee (all awardees) meet the 2012 Pandemic Influenza Plan (Public Health Component Meets Standards) requirement?			10.0%
Total Potential Withholding Percentage				20.0%

Scoring Criteria

The first three benchmarks are weighted the same, so failure to substantially meet any one of the three benchmarks will count as one failure and result in withholding of 10% of the fiscal year 2013 PHEP base award. Failure to submit the 2012 influenza pandemic plan as required may result in withholding of 10% of the fiscal year 2013 PHEP base award. More information on withholding and repayment is available in Appendix 13.

Appendix 11
HPP Exercises: Evaluation and Annual Progress Report Requirements

Exercise Program. To meet the applicable goals described in section 2802(b) of the PHS Act, all Budget Period 1 HPP funding applications must address the evaluation of state and local preparedness and response capabilities through exercises. Awardees must conduct annual preparedness exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP). Exercise programs funded all or in part by HPP cooperative agreement funding, or conducted to address the exercise requirements reflected in this cooperative agreement, should be built on HSEEP guidance and concepts. Further information on HSEEP guidelines and exercise policy can be found on the HSEEP website at: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

HPP awardees are also expected to work with relevant state and local officials to provide information for the National Exercise Schedule (NEXS), so that exercises can be coordinated across levels of government and healthcare entities. Additionally, at-risk populations and/or those who represent them must be engaged in preparedness planning and exercise activities.

Exercise Plans. Awardees must develop, refine, and submit a multiyear exercise plan for conducting substate regional or statewide, functional or full-scale exercises to test the HPP healthcare preparedness capabilities. Awardees are encouraged to develop joint exercises to meet multiple requirements from state agencies/departments receiving federal funds for preparedness exercises, and meet multiple requirements from the HPP to minimize the burden on exercise planners and participants. Exercise plans must demonstrate coordination with relevant entities such as local and substate regional healthcare coalitions, emergency management partners, emergency medical services, and local health departments. Coordination with local Medical Reserve Corps (MRC), National Disaster Medical System (NDMS), and Metropolitan Medical Response System (MMRS) entities and Cities Readiness Initiative (CRI) initiatives is strongly encouraged. Exercise plans should include methods to leverage resources to the maximum extent possible.

Awardees shall develop and submit exercise plans with their Budget Period 1 HPP funding applications. The exercise plan must include a proposed exercise schedule and a discussion of the plans for hospital, other healthcare organization, and healthcare coalition exercise development, conduct, evaluation, and improvement planning. This multiyear exercise plan must be updated annually and include the HPP requirement of showing how those mentioned above are incorporated and how required capabilities will be tested.

Within the exercise plan, the awardee must:

- Clearly delineate where exercises are being developed and conducted, the dates of those exercises, and the exercise objectives of hospitals, other healthcare organizations, and healthcare coalitions;
- Describe the role of hospitals, other healthcare organizations, and healthcare coalitions in exercise development, participation, evaluation, development of after-action reports, and participation in evaluation and improvement plans;
- Describe how the awardee will ensure that the lessons learned from after-action reports are shared with the hospitals, other healthcare organizations, and healthcare coalitions and how their emergency operations plans will then be modified; and
- Describe how plans for training are integrated into the exercise program.

Exercise Execution. During the five-year project period, awardees must:

- Ensure hospitals, other healthcare organizations, and healthcare coalitions participate in HSEEP-compliant substate regional or statewide, functional or full-scale exercises conducted in substate regions that encompass a healthcare coalition. The substate regions selected are determined by the priorities of the awardee during strategic planning. *Each substate regional or statewide, functional or full-scale exercise must address components of Capability 6: Information Sharing and Capability 4: Emergency Operations Coordination. Also during this exercise, at least <u>one</u> healthcare preparedness capability must be tested.*
- During the five-year project period, awardees are to plan for all substate regions that encompass a healthcare coalition to exercise as outlined above *and to test all healthcare preparedness capabilities*. This may require implementation of rotation strategies across the five budget periods to ensure different substate regional and any statewide exercise opportunities that may cover the state include healthcare systems. HPP awardees must ensure that all HPP participating hospitals participate in at least one substate regional or statewide HSEEP-based functional or full-scale exercise during the five-year project period.

Evaluation.

- Participate in the evaluation process as outlined in Capability 1: Healthcare System Preparedness; Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation;
- Describe the role of hospitals, other healthcare organizations, and healthcare coalitions in evaluation, development of after-action reports, and participation in evaluation and improvement plans;
- Describe how the awardee will ensure that the lessons learned from after-action reports are shared with the hospitals, other healthcare organizations, and healthcare coalitions, and how their emergency operations plans will then be modified; and
- Describe how plans for training are integrated into the exercise program; and
- HPP <u>encourages</u> putting after-action reports (AAR) for substate regional healthcare coalition-based exercises on the FEMA Lessons Learned Information Site (LLIS) at <u>http://www.llis.dhs.gov/</u> .

The following information must be addressed in each HPP annual progress report:

- Awardees must submit all after-action report summaries, improvement plans, and corrective actions that are developed for the aforementioned exercises and an executive summary of the priority three corrective action items, as well as a timeline for addressing those deficiencies.

Annual Reporting. HPP awardees will be required to report to ASPR as part of the end-of-year report the following information for each hospital participating in the exercise:

- Hospital name
- Hospital's national provider identification (NPI)
- Whether the hospital participated in:
  - Statewide functional exercise
  - Substate regional functional exercise
  - Statewide full-scale exercise
  - Substate regional full-scale exercise.

Other Funding Considerations. Additional activities for funding consideration under this requirement include:

- Enhancement and upgrade of emergency operations plans based on exercise evaluation and improvement plans (including those from the previous budget period);
- Release time for healthcare workers to attend exercises. (Note: Salaries for back filling are not allowable costs under this announcement); and
- Costs associated with planning, developing, executing and evaluating exercises.

Additional Resources: Additional exercise evaluation guides can be found and specifically crafted in the Homeland Security Exercise Evaluation Toolkit under Design and Development System (DDS).

Appendix 12
Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Compliance Requirements (*Revised February 2012*)

The ESAR-VHP compliance requirements identify capabilities and procedures that state[9] ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies. Each state must meet all of the compliance requirements.

ESAR-VHP Electronic System Requirements

1. Each state is required to develop an electronic registration system for recording and managing volunteer information based on the data definitions presented in the ESAR-VHP *Interim Technical and Policy Guidelines, Standards and Definitions* (*Guidelines).*

   These systems must:

   a. Offer Internet-based registration. Information must be controlled and managed by authorized personnel who are responsible for the data.

   b. Ensure that volunteer information is collected, assembled, maintained and utilized in a manner consistent with all federal, state, and local laws governing security and confidentiality.

   c. Identify volunteers via queries of variables as defined by the requester.

   d. Ensure that each state ESAR-VHP system is both backed up on a regular basis and that the backup is not co-located.

2. Each electronic system must be able to register and collect the credentials and qualifications of health professionals that are then verified with the issuing entity or appropriate authority identified in the ESAR-VHP *Guidelines.*

   a. Each state must collect and verify the credentials and qualifications of the following health professional occupations. Beyond this list of occupations, a state may register volunteers from any other occupation it chooses. The standards and requirements for including additional occupations are left to the states.

      1) Physicians (allopathic and osteopathic)

[9] For purpose of this document, state refers to the 50 states, the District of Columbia, the three metropolitan areas of Chicago, New York City, Los Angeles County, the Commonwealths of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the United States Virgin Islands, the Federated States of Micronesia, and the Republics of Palau and the Marshall Islands.

2) Registered nurses
3) Advanced practice registered nurses (APRNs) including nurse practitioners, certified nurse anesthetists, certified nurse-midwives, and clinical nurse specialists
4) Pharmacists
5) Psychologists
6) Clinical social workers
7) Mental health counselors
8) Radiologic technologists and technicians
9) Respiratory therapists
10) Medical and clinical laboratory technologists
11) Medical and clinical laboratory technicians
12) Licensed practical nurses and licensed vocational nurses
13) Dentists
14) Marriage and family therapists
15) Physician assistants
16) Veterinarians
17) Cardiovascular technologists and technicians
18) Diagnostic medical sonographers
19) Emergency medical technicians and paramedics
20) Medical records and health information technicians

b. States must add additional professions to their systems as they are added to future versions of the ESAR-VHP *Guidelines.*

c. To increase ESAR-VHP functionality immediately after a disaster or public health emergency, states are encouraged to develop expedited ESAR-VHP registration and credential verification processes to facilitate the health response. (ASPR will provide further information in a separate guidance document.)

3. Each electronic system must be able to assign volunteers to one of four ESAR-VHP credential levels. Assignment will be based on the credentials and qualifications that the state has collected and verified with the issuing entity or appropriate authority.

4. Each electronic system must be able to record all volunteer health professional/emergency preparedness affiliations of an individual, including local, state, and federal entities. The purpose of this requirement is to avoid the potential confusion that may arise from having a volunteer appear in multiple registration systems, e.g., Medical Reserve Corps (MRC), National Disaster Medical System (NDMS), etc.

5. Each electronic system must be able to identify volunteers willing to participate in a federally coordinated emergency response.

a. Each electronic system must query volunteers upon initial registration and/or re-verification of credentials about their willingness to participate in emergency responses coordinated by the federal government. Responses to this question, posed in advance of an emergency, will provide the federal government with an estimate of the potential volunteer pool that may be available from the states upon request.

b. If a volunteer responds "Yes" to the federal question, states may be required to collect additional information, e.g., training, physical and medical status, etc.

6. Each state must be able to update volunteer information and re-verify credentials every 6 months. (**Note:** ASPR is reviewing this requirement regularly for possible adjustments based on industry standards and the experience of the states.)

ESAR-VHP Operational Requirements

7. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all states must: 1) within 2 hours query the electronic system to generate a list of potential volunteer health professionals to contact; 2) contact potential volunteers; 3) within 12 hours generate a list of willing volunteer health professionals; and 4) within 24 hours provide the requester with a verified list of available volunteer health professionals that includes the names, qualifications, credentials, and credential levels of volunteers.

8. Each state must develop a plan to recruit and retain volunteers.

   ASPR will assist states in meeting this requirement by providing tools for accessing state registration sites and customizable materials and templates.

9. Each state must develop a plan for coordinating with all volunteer health professional/emergency preparedness entities to ensure an efficient response to an emergency, including but not limited to MRC units, NDMS teams, and the Federal Emergency Management Agency (FEMA) Citizen Corps.

10. Each state must develop protocols for deploying and tracking volunteers during an emergency (Mobilization Protocols):

    a. Each state is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. Included in these protocols must be plans to track volunteers during an emergency and for maintaining a history of volunteer deployments. ASPR may ask for copies of these protocols as a means of documenting compliance. ASPR will include protocol models in future versions of the ESAR-VHP *Guidelines*.

b. Each state ESAR-VHP program is required to establish a working relationship with external partners, such as the local and/or state emergency management agency and develop protocols outlining the required actions for deploying volunteers during an emergency. These protocols must ensure 24 hour/7 days-a-week accessibility to the ESAR-VHP system. There are three areas of focus:

    1) Intrastate deployment: States must develop protocols that coordinate the use of ESAR-VHP volunteers with those from other organizations, such as the MRC.

    2) Interstate deployment: States must develop protocols outlining the steps needed to respond to requests for volunteers received from another state. States that have provisions for making volunteers employees or agents of the state must also develop protocols for the deployment of volunteers to other states through the state emergency management agency via the Emergency Management Assistance Compact (EMAC).

       Each state must have a process for receiving and maintaining the security of volunteers' personal information sent to them from another state and procedures for destroying the information when it is no longer needed.

    3) Federal deployment: Each state must develop protocols necessary to respond to requests for volunteers that are received from the federal government. Further, each state must adhere to the protocol developed by the federal government that governs the process for receiving requests for volunteers, identifying available volunteers, and providing each volunteer's credentials to the federal government.

ESAR-VHP Evaluation and Reporting Requirements

11. Each state must test its ESAR-VHP system through drills and exercises. These exercises must be consistent with the ASPR Hospital Preparedness Program (HPP), Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness Program (PHEP), and ASPR ESAR-VHP program requirements for drills and exercises.

12. Each state must develop a plan for reporting program performance and capabilities. Each state will be required to report program performance and capabilities data as specified by the ASPR Hospital Preparedness Program (HPP), CDC Public Health Emergency Preparedness Program (PHEP), and/or the ASPR ESAR-VHP program.

Appendix 13
Withholding and Repayment Guidance

Procedural Consideration
This standard operating procedure (SOP) describes procedures ASPR and CDC will use to implement withholding or repayment actions in connection with the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) cooperative agreement program.

Pandemic and All-Hazards Preparedness Act (PAHPA) Requirements for the HPP and PHEP Cooperative Agreements
PAHPA requires the withholding of amounts from entities that substantially fail to achieve benchmarks or to submit an acceptable pandemic influenza operations plan:

A. **Benchmarks and Statewide Pandemic Influenza Operations Plan**

(1) Enforcement Condition: Awardees fail to substantially meet evidence-based benchmarks and/or fail to prepare and submit an acceptable pandemic influenza operations plan.

(2) Enforcement Action:

- Withhold funds – Budget Period 1 (fiscal year 2012) is for the purpose of evaluation to determine the amount to be withheld from the year immediately following year of failure. Additionally, each failure is to be treated as a separate failure for the purposes of the penalties described below:

  - Initial failure - withholding in an amount equal to 10% of funding per failure
  - Two consecutive years of failure - withholding in an amount equal to 15% of funding per failure
  - Three consecutive years of failure - withholding in an amount equal to 20% of funding per failure
  - Four consecutive years of failure - withholding in an amount equal to 25% of funding per failure

- Reallocation of amount withheld – according to Section 319C-1(g)(7), any HPP or PHEP funds withheld will be reallocated to the Healthcare Facilities Partnership program.

- Preference in reallocation – according to Section 319C-1(g)(7), any HPP or PHEP funds withheld will be reallocated to the Healthcare Facilities Partnership program in the same state.

Please note 319C-1(g)(6)(B) Separate Accounting: Each failure described under A(1) shall be treated as a separate failure for purposes of calculating amounts withheld under A(2). For example, a failure to achieve applicable benchmarks as a whole will count as one failure and a failure to submit a pandemic influenza operations plan will count as a second failure.

B. **Audit Implementation**

(1) Enforcement Condition: Awardees who fail to submit the required audit or spend amounts in noncompliance.

(2) Enforcement Action: Grants management officer disallows costs and requests payment via standard audit disallowance process or temporarily withholds funds pending corrective action.

C. **Carry-over**

(1) Enforcement Condition: For each budget period, the amount of total unobligated funds that exceed the maximum amount permitted to be carried over by the HHS Secretary.

(2) Enforcement Action: Awardees shall return to the HHS Secretary the portion of the amount of their total unobligated amount that exceeds the maximum amount permitted to be carried over unless waived or reduced. According to Section 319C-1(g)(7), any HPP or PHEP funds withheld will be reallocated to the Healthcare Facilities Partnership program, preferably in the same state.

WAIVE OR REDUCE: The awardee may request a waiver of the maximum amount of carry-over of unobligated funds or the HHS Secretary may waive or reduce the amount that must be returned for a single entity or for all entities in a fiscal year if the Secretary determines that mitigating conditions exist that justify the waiver or reduction. The Secretary will make a decision after reviewing the awardee's request for waiver.

The Department of Health and Human Services (HHS) permits awardees to appeal to the Departmental Appeal Board (DAB) certain post-award adverse administrative decisions made by HHS officials (see 45 CFR Part 16). ASPR and CDC have established a first-level grant appeal procedure that must be exhausted before an appeal may be filed with the DAB. CDC will follow the process outlined in 42 CFR § 50.401 et seq. which is applicable to CDC by its terms. ASPR will also follow the process outlined in 42 USC 50.401 et seq. for HPP awards when addressing disputes of the nature listed in 42 USC 50.404.

Appendix 14
HPP-PHEP Awardee Resources

Administrative Preparedness – Legal Authorities

- Joint Public Health-Law Enforcement Investigations: Model Memorandum of Understanding- http://www.nasemso.org/Projects/DomesticPreparedness/documents/JIMOUFinal.pdf

Capabilities

- Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.
- Public Health Preparedness Capabilities: National Standards for State and Local Planning - http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

ESF#8

- Emergency Support Function #8 (ESF #8) – Public Health and Medical Services Annex http://www.fema.gov/emergency/nrf/

Executive Directives

- Presidential Policy Directive 8: National Preparedness - http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm
- Strategic National Risk Assessment in Support of PPD 8: A Comprehensive Risk-Based Approach toward a Secure and Resilient Nation - http://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf
- National Health Security Strategy - http://www.phe.gov/preparedness/planning/authority/nhss/Pages/default.aspx

Exercise and Evaluations

- Homeland Security Exercise and Evaluation Program Guidance - https://hseep.dhs.gov/pages/1001_HSEEP7.aspx

HAvBED

- HAvBED EDXL Communication Schema - https://havbedws.hhs.gov
- HAvBED Web Portal - https://havbed.hhs.gov

HHS Office of the Assistant Secretary for Preparedness and Response

- http://www.phe.gov/preparedness/pages/default.aspx

HHS Centers for Disease Control and Prevention

- Office of Public Health Preparedness and Response - http://www.cdc.gov/phpr/
- Funding, Guidance, and Technical Assistance – http://www.cdc.gov/phpr/coopagreement.htm

- Division of Strategic National Stockpile – http://www.cdc.gov/phpr/stockpile/stockpile.htm

HPP Healthcare Systems Evaluation Branch (HSEB) Resources

- Hospitals Rising to the Challenge: The First Five Years of the U.S. Hospital Preparedness Program and Priorities Going Forward - http://www.upmc-biosecurity.org/website/resources/publications/2009/pdf/2009-04-16-hppreport.pdf
- The Healthcare Facilities Partnership Program and Emergency Care Partnership Program Evaluation Report - http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-hfpp_eval_rpt.pdf
- The Next Challenge in Healthcare Preparedness: Catastrophic Health Events - http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-prepreport.pdf
- National Healthcare Preparedness Evaluation & Improvement Conference - http://publichealthemergency.hhs.gov/Preparedness/planning/nhpeic/Pages/default.aspx
- Phase 1: Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report - http://www.iom.edu/Reports/2009/DisasterCareStandards.aspx
- Phase 2: Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report - http://www8.nationalacademies.org/cp/projectview.aspx?key=49130
- Evidence Review on the Allocation of Scarce Resources During Mass Casualty Events (MCEs) - http://www.ahrq.gov/clinic/tp/scarcerestp.htm
- Home Health Care During an Influenza Pandemic: Issues and Resources - http://www.flu.gov/professional/hospital/homehealth.html.

Lessons Learned

- FEMA Lessons Learned Information Site (LLIS) - http://www.llis.dhs.gov/

Pandemic and All-Hazards Preparedness Act (PAHPA)

- PAHPA Overview - http://www.phe.gov/preparedness/legal/pahpa/pages/default.aspx
- PAHPA Full Text - http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ417.109.pdf

Preparedness Reports

- CDC State Preparedness Reports - http://www.cdc.gov/phpr/pubs-links/pubslinks.htm
- From Hospitals to Healthcare Coalitions: Transforming Health Preparedness & Response in Our Communities - http://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-healthcare-coalitions.pdf

Research Activities

- Distinguishing Public Health Research and Public Health Non-Research - http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-

health-research-nonresearch.pdf